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PHYSICIANS' EDITION

PHOTOGRAPHIC ATLAS
OF THE
DISEASES OF THE SKIN
IN FOUR VOLUMES

*A Series of Ninety-six Plates, Comprising nearly Two Hundred
Illustrations, with Descriptive Text, and a Treatise
on Cutaneous Therapeutics*

BY
GEORGE HENRY FOX, A.M., M.D.

PROFESSOR OF DERMATOLOGY, COLLEGE OF PHYSICIANS AND SURGEONS, N. Y.
CONSULTING DERMATOLOGIST TO THE DEPARTMENT OF HEALTH, NEW YORK CITY
PHYSICIAN TO THE NEW YORK SKIN AND CANCER HOSPITAL
ETC.

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PRURIGO

THE name prurigo has been applied by former writers to many eruptions of varied character, in which severe itching is the prominent symptom.

It is now restricted to a definite disease which begins in early life, and persists usually in spite of treatment. It is characterized by a peculiar dryness of the skin, with pale shotty papules, chiefly on the extensor aspect of the extremities, and a pruritus so intense as to cause numerous excoriations, urticarial lesions, thickening and pigmentation of the skin, and often a notable enlargement of the superficial lymphatic glands. A severe form of the disease (prurigo ferox) is common in Austria and other parts of Europe, but in this country such cases are extremely rare. Even the mild form (prurigo mitis) does not often occur, and the few cases which are met with are apt to be regarded as instances of persistent papular eczema. The diagnosis must depend upon the early development of the disease, its chronicity, and the characteristic location of the lesions.

The treatment of prurigo will usually ameliorate the condition of the skin, even if it fails to effect a complete cure. Hot baths, soap frictions, and stimulating inunctions are called for in most cases. Vlemingk's solution (page 20), applied either pure or diluted with from one to ten parts of water, is perhaps the best local application. If the skin is very dry, good results may be obtained from the use of Wilkinson's ointment, made according to the following formula :

B. Sulphuris præcipitati	ziss	15
Olei ruscii	fziss	15
Crete preparatæ	gr. xl	10
Saponis mollis	ziss	25
Adipis	ad ziss ad	100

If eczematous patches complicate the disease, the use of vulcanized rubber underwear, worn with the rubber side next the skin, may prove of value. Naphthol (two to five per cent.) in oxide of zinc ointment may be smeared upon pieces of muslin and applied to the limbs beneath a roller bandage. Kaposi has long used this remedy, and claims that it diminishes the itching at once, has no disagreeable odor, and does not soil the linen. The local treatment should be continued until the skin is smooth and all itching has ceased. Applications may then be made less frequently until the skin has remained smooth for a month or more.

Arsenic, according to Zeisler, exerts little, if any, influence upon the eruption, even if given perseveringly and in full doses. Pilocarpin, used subcutaneously, will produce a profuse perspiration and thereby soften the skin, but its incidental effects require that it should be used with great caution. Antipyrin, in doses of one to three grains, has been found serviceable by Blaschko and others in lessening the intense pruritus and controlling the urticarial symptoms. Crocker relieves the itching by giving full doses of the tincture of cannabis indica. For a child of eight or ten he begins with five minims, and increases it even to thirty minims, three times daily, directly after meals. An interval of a fortnight in its administration should be allowed about every six weeks, since when taken in large doses for a long period it may produce dullness of intellect and loss of memory, which soon passes off, however, when the drug is suspended.

Since cases of prurigo here and elsewhere are usually found in the lower stratum of society, attention should be paid to the betterment of the patient's hygienic surroundings. Nutritious food, with cod liver oil, malt extract, and bitter tonics, will often strike at the root of the disease and enhance the value of local remedies. It is also important to continue general treatment, frequent hot baths, and inunctions long after the skin has become comparatively smooth and soft, as early cessation of the treatment is certain to be followed by a speedy relapse.

PRURITUS

Itching is a prominent symptom of eczema, urticaria, scabies, phthériasis, and many other skin diseases. Often it occurs alone as the result of hepatic or renal disease, or of some obscure internal condition, and to this cutaneous disorder, with the resulting excoriations, the term pruritus is applied. It is, in fact, a neurosis of the skin. It may occur at any age, but is apt to be especially annoying and intractable in the decline of life (pruritus senilis). It may occur at all seasons, but is very frequently noted at the advent of cold weather, and persists in some cases only during the winter (pruritus hiemalis). It may affect the body generally, or be limited to certain regions, *e.g.*, the nostrils, anus, scrotum, or vulva.

Pruritus results from a great variety of causes, both predisposing and exciting. The source of the affection often remains obscure even after a most careful study of the case, and frequently it is much easier to remove this by measures which improve the mental and physical condition of the patient than it is to determine its precise location and character. Jaundice, diabetes, gout, malaria, dyspepsia, and neurasthenia are diseases which often underlie the cutaneous pruritus and demand therapeutic recognition. Improper food, excessive use of tobacco, coffee and certain drugs, intestinal worms, hemorrhoids, etc., must always be regarded as possible sources of the external irritation, and proper measures taken to arrest their detrimental action.

Of all diseases of the skin pruritus is the one in which a routine plan of treatment is most certain to fail. Its etiology is so varied that unless great patience and skill are exercised in the examination of a case no treatment will be likely to accomplish any brilliant result. If the cause of the pruritus can be discovered and removed, the treatment of the cutaneous lesions becomes a simple matter. The general treatment of the patient who suffers from intense pruritus is always of prime importance. The treatment of the patient's skin can only be regarded as a palliative measure.

The use of narcotics in the treatment of pruritus may sometimes seem advisable for a brief period, but they soon lose their effect when continued indefinitely and often do far more harm than good. Opium is especially objectionable, since it not only tends, like cocaine, to induce a pernicious habit of reliance upon the drug, but it usually aggravates the pruritus. Bulkley has recommended both cannabis indica and gelsemium as internal remedies, and in general pruritus good results may be obtained from their temporary use. In my experience the bromides have proved quite as efficient in the treatment of adults, and may be pushed without the danger of unpleasant toxic symptoms.

Baths are of great service in cases of general pruritus, and may be plain or medicated. The cool tub bath in the morning will invigorate both the skin and the nervous system, and may be safely advised even for elderly patients and those who imagine that all sorts of evil may result from such a procedure. A hot bath at night usually has a sedative effect and tends to induce sleep, and when salt in large quantity is added, as recommended by Pissard, a decided antipruritic effect is attained.

The underclothing of a patient suffering from pruritus may tend to irritate the skin, and the wearing of thin garments of silk or linen beneath the ordinary woollen underwear will often relieve the itching and any urticarial complications. In the winter season, or in a climate where sudden changes of many degrees are frequent, the clothing should be regulated in such a manner as to keep the body warm at all times, and at an even temperature.

External applications in the treatment of pruritus are often found to be of great service, since they alleviate the distress of the patient, even though they may not strike at the root of the disease. They may be used in the form of powders, lotions, oils, or ointments.

Alcohol rubbed into, painted over, or, better still, sprayed upon the skin, relieves pruritus temporarily by virtue of the cooling effect produced by its rapid evaporation. Chloroform liniment is another remedy which, though seldom used for this purpose, is capable of allaying itching in a marked degree.

Carbolic acid, on account of its power of inducing a certain amount of local anaesthesia, is one of the most reliable of all antipruritics. As commonly used in a weak solution, it does but little good, but when a solution is used of sufficient strength to almost burn the skin the relief of the pruritus is always marked, and only in cases where there is an inflammatory condition present is it likely to do harm. Over the whole skin, and especially in children, it should be used with caution in order to avoid the possible intoxication from absorption. The following lotion is a cleanly and most effective one, which I have used with success in many cases :

B	Acidi carbolici	20
	Glycerini	20
	Aquæ	ad 100
m		

S.—Apply with caution, and dilute if necessary.

A more lasting effect is produced when the acid is mixed with oil or fat, and the following formula is highly recommended by Bronson :

B	Acidi carbolici	f ₂ i-ii	12	25
	Liquoris potassii	f ₃ i		12
	Olei lini	ad f ₂ i		ad 100
m				

Menthol, thymol, cocaine, tar, corrosive sublimate, potassium cyanide, and hydrogen dioxide may also be found of service. A mixture of chloral and camphor, which forms a fluid, has been used with success by various writers. This may be incorporated in an animal oil or ointment and thoroughly rubbed into the skin.

In cases of intense general pruritus, when nearly all remedies have failed, I have found galvanism, applied to the skin by means of a metallic roller, to produce an almost magical, though temporary, effect. With each successive application of the electricity the relief from the itching is apt to be more prolonged.

PURPURA

Hemorrhage into the cutaneous tissue or from a mucous surface may result from a variety of causes. Upon the skin it occurs in the form of small, bright red spots (petechiæ), diffused bluish red patches (ecchymoses), or a dark tumor due to the rupture of a larger and deeper vessel (hæmatoma). The hemorrhagic lesion always appears suddenly, does not disappear under pressure of the finger, and usually exhibits a series of tints of red, purple, blue, green, and yellow, as the effused blood is gradually absorbed.

The term purpura is not applicable to cutaneous hemorrhage resulting from bruises or other external injury, or occurring in connection with eruptive fevers such as small-pox and measles, and in various erythematous and bullous affections. It should be restricted to an idiopathic hemorrhage, which may involve the skin or the mucous membranes.

Several clinical forms of purpura are usually described. Purpura simplex occurs chiefly upon the legs, although the thighs, neck, and chest may also present the eruption. The lesions appear suddenly and in successive crops, so that notable contrast is often observed between the bright red of fresh spots and the dull hue of older lesions.

Purpura rheumatica is a less common form of the disease, in which pain and swelling of the knees, ankles, or other joints are noted in addition to the hemorrhagic eruption, which is apt to be elevated, and to resemble an exudative erythema.

Purpura hemorrhagica is a severe form of the disease, in which there is fever and general prostration. There are serious hemorrhages from various mucous membranes in addition to the cutaneous eruption, which usually assumes the form of large ecchymoses upon the trunk and extremities.

Purpura scorbutica or "scurvy" is a term which has long been applied to the same affection when occurring among sailors on long voyages, soldiers on poor or short rations, prisoners in crowded jails, and others unable to enjoy the benefits of good food, fresh air, and outdoor exercise.

The treatment of purpura depends upon the type and severity of the individual case. In the simple form a spontaneous recovery in a few weeks is often noted, and this may be favored by complete rest and the administration of the tincture of the chloride of iron in full doses. Quinine, *nux vomica*, and the mineral acids, will often give tone to the patient's system and indirectly hasten the course of the eruption.

Since the arthritic type of purpura frequently occurs in those who suffer or have suffered from rheumatic attacks, the salicylates and other anti-rheumatic remedies will be found of service. Potassium iodide is especially valuable, not only for the rheumatic symptoms, but for the purpose of hastening the absorption of the purpuric spots. Treatment of rheumatic purpura should be continued for some time after the cutaneous lesions and arthritic symptoms have passed away, as relapses are not uncommon.

In the treatment of purpura hemorrhagica absolute rest in bed, with freedom from all care and mental anxiety, is of prime importance. The most nutritious diet, with wine, unless a febrile condition forbids, is necessary to keep up the strength of the patient. Among internal remedies, iron, turpentine, and ergot have been used with probably the best results, although their administration has not always prevented a fatal termination.

The iron tincture is best given in glycerin, and the turpentine, in ten to thirty minim doses, on lumps of sugar. The fluid extract of ergot may be given in carbonated water, one half drachm every three or four hours. When the hemorrhage is serious, its hypodermic use is preferable. *Hamamelis*, *hydrastis*, *arnica*, and other remedies have also been recommended for internal use, but are not to be relied upon in severe cases.

For bleeding of the gums, astringent mouth-washes may be used, or a three per cent. solution of cocaine applied by means of a camel's-hair brush. Small pieces of ice will sometimes relieve gastric or rectal hemorrhage.

Local applications have little effect upon the cutaneous lesions. Elevation of the limbs, with the use of light cheese-cloth bandages, may prove of service. Vidal recommends the application of compresses, soaked in a one to two per cent. solution of ammonium chloride.

ROSACEA

Rosacea is a disease which has long been associated with acne, and is still described by most writers under the name of acne rosacea. While often presenting inflammatory lesions which bear a strong resemblance to the pustules of chronic acne, it is also characterized by a development of superficial blood vessels, and an increase of connective tissue, which give it a place among the hypertrophic affections. Three clinical forms are recognized and described as rosacea erythematosa, rosacea pustulosa, and rosacea hypertrophica. It is the pustular form which bears the strongest clinical resemblance to acne, but may be differentiated by the fact that it occurs in middle life instead of in youth, affects chiefly the central vertical third of the face, and is not associated with comedos and an impaired function of the sebaceous glands.

Rosacea usually presents dull red nodules on the nose and malar region, and sometimes on the forehead and chin. These may be due to some form of alcoholic indulgence, but all dietetic errors which cause irritation of the stomach and a consequent flushing of the face will tend to produce them. In fact, the term "dyspepsia blossoms" would be more comprehensive and more applicable to all cases than the well-known name of "rum blossoms."

In the treatment of rosacea the circulation and digestion of the patient should be carefully considered before any thought is directed to the cutaneous condition. If a man saw another shivering with cold on a bleak corner, and wished to restore his pinched and blue nose to a normal condition, he would probably suggest to him to go indoors and get warm. If he saw another one indulging in supernumerary cocktails or irritating his stomach in some one of many other common ways, he would surely not expect to dissipate the resulting nasal blossoms by the mere application of a topical astringent. And yet many physicians strive to cure rosacea by the local use of

soap, sulphur, ergot, etc., without paying the slightest attention to the cause of the trouble. While it is true that stimulating local remedies often produce a notable improvement in the patient's appearance, they do not strike at the root of the disease, and are therefore incapable of effecting a permanent cure. In rosacea, as in many other cutaneous affections, the importance of judicious regulation of the diet, systematic outdoor exercise, and cold bathing as therapeutic agents can hardly be overestimated.

In the erythematous form of rosacea the lower portion of the nose is often persistently reddened, and this condition, like the cold hands and feet with which it is usually associated, is simply due to a sluggish circulation. The patient's lungs are rarely expanded to their full capacity and the heart's action is weak. In such a case simple gymnastic exercises, frequently repeated during the day, will serve to lessen the congestion of the head by drawing more blood to the lungs and quickening the circulation through the extremities. The patient, especially if a young girl, will do well to renounce corsets and tight collars. She should be made to acquire the habit of sitting erect at all times and walking with the chin never in advance of the breast bone. It is not generally known how much a correct posture, combined with frequent forced inspiration, will do in relieving facial congestion and improving a girl's complexion. This chronic redness of the nose is sometimes associated with an oily condition of the skin, which may be greatly benefited by the frequent application of sulphur in either powder or lotion.

When gastro-intestinal irritation exists strict dietetic measures are called for. The only indication of this irritation may be a frequent flushing of the face or an increased redness of the nose after hot drinks or hearty meals. Tea and coffee, as well as alcoholic stimulants, and even soup, should be forbidden. Excessive use of tobacco, and especially cigarette smoking, is apt to weaken the circulation, to favor reflex hyperaemia, and thereby to aggravate an erythematous rosacea.

In the pustular form of rosacea the same attention should be paid to the patient's general condition, while local treatment of the most vigorous

character may be instituted. Soap frictions, strong sulphur lotions, and all stimulating applications, however they may irritate and redden the face temporarily, are certain to quicken the sluggish circulation and cause the affected skin to become smoother and whiter. In the local treatment of rosacea pustulosa, as in chronic acne, the curette will be found of great value. Once or twice a week the face should be scraped as energetically as the patient will permit. The bleeding excoriations left in place of the pustules grow less with each repeated curetting, and soon the instrument will merely redden the skin. The "bubuckles and whelks and flames of fire" which characterized the countenance of Sir John Falstaff will disappear very speedily from any other rosaceous face under the unsparing use of the ring curette or sharp spoon. After vigorous curetting an antiseptic lotion should be sponged over the face. This lotion or a soothing ointment may be used daily by the patient, although it is by no means necessary.

The hypertrophic form of rosacea demands treatment of a surgical character, as the strongest ointments cannot remove the increased growth of tissue. Vigorous massage will often evacuate a large amount of sebaceous matter from the glands upon the tip and wings of the nose, thereby lessening its size to a considerable extent and reducing its color in a slight degree. Multiple incision, deep linear scarification, or the use of the electrolytic needle, will serve to reduce the size of the nose and sometimes effect a brilliant result. But when soft, pendulous, lobular masses are present their removal by the knife is the simplest and surest method of treatment. Often the excision of one or more wedge-shaped masses of hypertrophic tissue will greatly improve the patient's appearance.

The dilated and branching capillaries (telangiectasis) often seen upon the wings of the nose, with or without rosacea, can best be destroyed by inserting the electrolytic needle at the point where the vessel first appears upon the surface of the skin. The small, tortuous veins upon a hypertrophied nose may be made to disappear by inserting the needle at one or two points along their course.

SCABIES

Scabies, commonly known as "the itch," is a disease caused by the burrowing of an insect (*acarus scabiei*) in certain regions where the skin is thin, as on the web of the fingers, axillary folds, penis, and scrotum. The resulting eruption is characterized by numerous excoriated papules, and is found chiefly on the hands and forearms, the female breasts, the male genitals, the lower portion of the abdomen, and inner surface of the thighs. As the common name implies, the disease is an intensely pruriginous one, and the itching is especially severe at night when the patient is in a warm bed. It is contagious, and very apt to affect several in one family. It is usually acquired by sleeping with an affected individual, or in a bed which such a one has occupied.

In the treatment of scabies sulphur has long been, and is likely to remain, the standard remedy. Styrax, naphthol, and various other remedies have been recommended, and a number of formulae of parasiticide ointments are usually given in every text-book, but nothing is simpler, cheaper, and more effective than plain sulphur ointment. A few suggestions as to its proper use will, therefore, be of more use than a discussion of other remedies which may be of undoubted value, but can lay no claim to superiority.

The main object of treatment is to destroy the acari and to cure the eruption which has resulted from their presence in the skin. The official sulphur ointment (3 in 10) is well adapted to the accomplishment of both these ends. In the case of children or patients with an extremely delicate skin, or when a secondary eczema has resulted from persistent scratching, the ointment may be diluted with one or two parts of vaseline.

The treatment should begin with a prolonged hot bath at night for the purpose of macerating the skin, so that the burrows of the insect may be more readily destroyed. The hands should then be scrubbed thoroughly with soft soap and the same applied more gently to the axillary region, genitals, and

other parts where the acari are prone to burrow. After the skin is dried, the sulphur ointment should be rubbed well into the parts which have been scratched most severely, and the patient directed to sleep in tight-fitting underclothing. This may be worn constantly for three days, the ointment being reapplied morning and night. The patient may then take a second hot bath, and in most cases no further treatment is required. Should a return of the itching be noted the same programme, including the hot bath, soap friction, and sulphur inunctions may be repeated. In very chronic cases the period between the baths may be five instead of three days.

Sulphur rarely produces any irritation of the skin when eczema is not present, but such a possibility must be borne in mind. If the pruritus persists after the above treatment has been carried out, it may indicate that either an error in diagnosis has been made or that the sulphur, and not the scabies, is now the cause of the itching. In either case its use should be discontinued.

The use of sulphur powder in place of the ointment, as recommended by Sherwell, has found favor with some, and is certainly a more agreeable method of treatment in private practice. Though in chronic cases it may not be equal in efficacy to the ointment, it is capable of curing most patients. By the ease with which it can be dusted over the bed and underclothing it is well adapted to prevent a return of the disease from reinfection.

SCLERODERMA

Scleroderma is a rare disease in which an indurated or "hide-bound" condition of the skin is noted. It is usually chronic in its course and may affect a limited region, or involve the head, trunk, and upper extremities. At first there is an infiltration of the skin, imparting to the surface a characteristic hardness and pallor. Later this may disappear and leave an atrophied and tightly drawn condition of the integument. In some cases the infiltration disappears and leaves a normal skin.

The cause of scleroderma is obscure. The affection is often associated with

the rheumatic diathesis, and exposure to cold and damp air may possibly give rise to it, as it certainly tends to aggravate it. It occurs in children as well as in adults, and women appear more subject to the disease than men.

The treatment of scleroderma is rarely attended by any brilliant therapeutic result, and often seems of little or no benefit. But since a spontaneous disappearance of the disease has at times been noted, a persistent effort should be made in every case during the stage of infiltration to restore the skin to its normal condition. When the disease has progressed until the atrophic stage has been reached, all hope of a cure becomes delusive.

The general health of the patient can often be greatly improved by systematic outdoor exercise and a nutritious diet, including koumyss, malt extract, and cod liver oil in large doses, if the patient's stomach will tolerate it. Internal remedies have been found to be of little or no service so far as their direct effect upon the hardened skin is concerned. But when a rheumatic condition is present, as often happens, the alkalies, salicylates, and salol may be prescribed with benefit. The patient should be removed to a warm and equable climate when this is practicable, or made to dress in such a manner that the skin will not be affected by any sudden change of temperature. The Turkish bath has been highly recommended in the treatment of scleroderma, and if taken frequently will improve the condition of the skin in most cases.

In the local treatment of the disease, massage is of the first importance, and in no other affection of the skin is this remedy of greater service. In combination with massage the inunction of cod liver oil has been employed; but the main object of the massage is to stimulate the cutaneous circulation in the ischaemic regions. Whether dry or oiled hands are used, the massage must be employed skilfully, frequently, and persistently. Galvanism is another agent which tends to stimulate the cutaneous circulation, and I have seen excellent results follow its use. Hyde advises brisk rubbing of the whole body with salt, partially dissolved in hot water, followed by warm bathing and finally cold affusion.

SCROFULODERMA

Under the name of scrofula or struma many cutaneous eruptions have formerly been classed, some of which were syphilitic, a few inflammatory or eczematous, and many of tuberculous origin. The chief symptoms of scrofula have been described as indolent inflammation of the skin, caseous degeneration of the lymphatic glands, with the subsequent occurrence of characteristic ulceration. Visceral disease, tumefaction of the belly, chronic keratitis coryza, otorrhœa, and chronic arthritis or dactylitis are usually coincident indications of the peculiar diathesis.

The chief cause of scrofulous lesions, which were formerly attributed to an inherited taint, has been found by modern research to be the tubercle bacillus or toxins in the tissues affected; or a cachexia resulting from the tuberculous condition of some internal organ. Some, therefore, class scrofuloderma as a tuberculosis cutis, or, if the bacilli are not present, as a para-tuberculosis.

The treatment of scrofuloderma depends upon the extent of the disease. For the general condition of the patient cod liver oil and iodine have long been the favorite and most effective internal remedies. Combined with fresh air and a nutritious diet, these will often produce a decidedly beneficial effect. The best effect of cod liver oil can only be obtained by coaxing the patient to take the largest amount which the stomach will tolerate, and to continue this for several months. Iodine may be given in the form of the syrup of the iodide of iron or the iodide of starch, a dark powder, of which one to four drachms may be taken three times daily in milk or gruel. When glands have softened or ulceration is present, a surgical method of treatment is usually required, and the curette may be freely used. The healthy ulceration which results will usually heal speedily. When healing is slow the raw surface may be sprayed with an ethereal solution of iodoform.

SYCOSIS

SYCOSIS is an inflammatory affection of the hair follicles, usually of the bearded portion of the face. It is, therefore, almost exclusively limited to the male sex. The characteristic lesions are papules or pustules, each perforated by a hair. The disease is non-contagious, and has no more claim than acne to be considered as a parasitic affection, notwithstanding the presence of pyogenic micro-organisms. What has been termed by some writers a parasitic form of sycosis is simply ringworm (trichophytosis barbæ). The presence of this disease may sometimes occasion a secondary sycosis, as it often does a secondary eczema, but in such a case we have two distinct diseases to deal with.

The cause of sycosis may be either of a general and predisposing, or of a local and exciting character. In the great majority of cases both of these etiological factors are present. In the pustular lesions of sycosis staphylococci are readily found, and some have regarded these organisms as the parasitic cause of the disease. Occasionally a strong, robust man may suffer from sycosis as he may suffer from a furuncle, and it would seem as though some local infection, possibly of a contagious nature, were responsible for the affection. But in most cases, sycosis, like acne, depends upon, or at least is aggravated by, systemic conditions which predispose to the cutaneous inflammation. These produce what is commonly termed a favorable soil for the pyogenic germs, and are of prime importance in the development of most cases. I cannot agree with Crocker in regarding sycosis as a purely local disease, but would claim, with Robinson, that hereditary vulnerability of the skin, impaired nutrition of the body, and disorders of the intestinal tract, as well as all injurious local agents, whether acting mechanically, chemically, or thermically, can make the ground favorable for a sycosis.

Upon the cheeks local irritation, such as the use of impure or alkaline soap, does not play as important a part in the causation of the disease as some have alleged. But in that form which so often affects the central portion of the upper lip, local irritation is an important etiological factor. A chronic catarrhal rhinitis will almost invariably be found to exist, and the acrid discharge from one or both nostrils will keep up the sycotic inflammation of the lip immediately beneath. In such a case treatment of the nose must either precede or accompany the measures directed to the cure of the sycosis.

In the treatment of sycosis local applications will sometimes effect a cure, but in many cases the inflammatory process will persist, in spite of either soothing or stimulating ointments. In such obstinate cases it is only after the patient's general condition has been carefully studied and some decided improvement occasioned by judicious hygienic or tonic treatment that the local disease will yield.

Internal remedies have no direct effect upon the local inflammatory process, but, indirectly, they may be of service. Laxatives and alkaline diuretics will tend to lessen the acute hyperæmia which is often present. Bitter tonics will serve to tone up an impaired digestion, while cod-liver oil may be administered with a view to overcoming the nutritive debility which is often at the root of the disease.

In the local treatment of sycosis, shaving or clipping the hairs, and epilation of such as have been loosened by the follicular inflammation, is the first step. In most cases the bearded portion of the face can be shaved carefully every second day, but if the inflammation is intense and the pustules numerous, the patient may object strongly to the use of a razor. If so, the hairs may be cut as short as possible with a pair of sharp, curved scissors. Another objection to shaving has been raised to the effect that when carelessly performed it is apt to irritate and abrade the skin, and thereby to aggravate the disease through the increased opportunity thus offered for the multiplication of pus organisms.

Epilation is called for in nearly every case of sycosis. When the in-

flameation is very acute only the loosened hairs should be removed, and even this is sometimes the cause of severe pain. Large and powerful men will sometimes shrink and protest after the forceps have accidentally made slight traction on a firmly imbedded hair. The pain of the operation may be somewhat lessened by first applying cotton dipped in very hot water to the inflamed skin, or rubbing over the surface a thin ointment containing menthol. When the inflammation is not so acute the hairs may be removed from all the pustules, and in a chronic case it is often advisable to thoroughly epilate a large patch.

In the use of lotions and ointments in the treatment of sycosis, regard should always be paid to the grade of inflammation. Though the disease is usually chronic—i. e., of long standing—the inflammatory lesions are often so extremely acute and tender that any stimulating application is apt to do more harm than good. A mild zinc or boric acid lotion may be used when inflammation is intense, and later superseded by an astringent or parasiticide ointment. The following have been used with success:

R	Acidi tannici	gr. xlv	8
	Sulphuris præcipitati	gr. xlv	8
	Zinci oxidii	ʒ ss	20
	Amyli	ʒ ss	20
	Petrolati mollis	ʒ i ad 100	

ml

(ROSENTHAL)

R	Hydrargyri chloridi corrosivi	gr. i	.20
	Acidi carbolici	gtt. x	2
	Unguenti zinci oxidii	ʒ i ad 100	

ml

(ROBINSON)

In the chronic thickened condition of the skin sometimes resulting from persistent sycosis, soap frictions and ointments of a more stimulating character can be employed. The vigorous use of a curette will often be found of service.

SYPHILODERMA

Syphilis is a disease concerning which enough volumes have been written to fill a large library. Its cutaneous manifestations consist of the chancre or initial lesion, which usually appears from two to four weeks after infection, and the characteristic eruptions, which first develop about two months later, and may appear after a lapse of many years. The syphilodermata, or cutaneous syphilides, may be conveniently divided into those which appear during the first year (usually during the first three months) and those which are liable to develop after the first year, and are usually called the late syphilides. The former are macular, papular, or pustular, and affect the greater portion of the body in a symmetrical manner. The latter are nodular or gummatous, and show a marked tendency to grouping and localization in a limited area in place of being symmetrical like their predecessors. Scaling, crusting, and ulceration may occur in both the early and late syphilodermata, and greatly modify their clinical appearance.

The treatment of cutaneous syphilis is, in most cases, a very simple matter. In fact, the disease tends to run its course like the acute exanthemata, though much more slowly, and most cases occurring in those who inherit a good constitution, and who avoid all kinds of dissipation, would probably get well without any systematic treatment. The prevalent idea that the disease, if not treated vigorously, is certain to destroy the patient's health and to shorten his life, is not in accordance with the facts of everyday observation. It is true that in weak and strumous subjects, and those addicted to alcoholic excesses, the disease may occasion both disagreeable and alarming symptoms, but in the great majority of cases it presents a benignant form and tends to spontaneous recovery.

The curability of syphilis has long been a subject of discussion, but the old idea that a man who contracts syphilis must live and die a syphilitic, and that even his ghost will be a syphilitic, has few if any supporters at the present day. Many men who contract syphilis, and are properly treated for a year or more, go through life without any subsequent

manifestation of the disease. Those who marry a few years after infection usually beget healthy children, and though cases do occur in which the disease occasions serious and sometimes fatal accidents late in life, or in which it is transmitted to offspring resulting from marriage many years after infection, these must be regarded as exceptions to the rule. There are few, if any, constitutional diseases so amenable to treatment as syphilis, and so certain to be cured by proper management.

In the treatment of the chancre or "primary syphilis" attempts have been made to prevent, by means of thorough cauterization or excision, the occurrence of the constitutional disease. The result has usually been unsuccessful, and even in cases where a successful result has been reported there always remains a doubt as to whether the lesion destroyed was a simple venereal sore or the initial lesion of syphilis. With this uncertainty as to any possible benefit, it is advisable to refrain from either cauterization or excision. The former practice does no good, and often tends to increase the induration of the lesion and render it more difficult to cure. In the case of an unmistakable hard chancre upon a redundant prepuce, circumcision might prove advantageous to the patient, even if it failed to prevent the constitutional manifestations of the disease. In most cases simple measures are to be preferred. The penis, or other affected part, should be kept scrupulously clean by daily washing, and the surface, if raw, dusted frequently with calomel or boric acid. When deep ulceration is present iodoform is the best application.

The question as to whether mercury should be given internally in the primary stage of syphilis has elicited much discussion, and most writers agree in condemning the practice. That it will tend to lessen the induration of a persistent chancre is beyond all doubt. That it can do any direct harm in this stage of syphilis has been claimed by some, but never proven. If a patient has a lesion which is certain to be followed by secondary symptoms, the sooner mercury is administered internally the better effect will it have upon the course of the disease. But who can say with absolute positiveness in all cases that a given sore or induration is the primary lesion

of syphilis? When mercury is given at this time for the healing of a chancre, the subsequent evolution of the disease is delayed and often modified to such an extent that an uncertainty may arise as to whether the patient really has syphilis or not, and in such a case the necessary treatment often fails to be carried out for a desirable length of time. On the other hand, when mercury is administered for a simple venereal sore, erroneously supposed to be syphilitic, the patient is often treated for months or years unnecessarily, and is doomed to go through life in constant dread of some manifestation of a disease which he has never contracted.

The indirect harm which may therefore result from the early administration of mercury far more than counterbalances the slight loss of time resulting from the postponement of internal treatment until the constitutional symptoms have appeared, and when doubt can no longer exist as to the nature of the patient's disease.

When the constitutional infection has manifested itself in the form of a macular or papular eruption upon the skin, the systematic treatment of the disease may be said to begin. The patient should at once be made acquainted with the nature of the disease from which he is suffering, the impossibility of a rapid cure, and the necessity of continuing treatment, or, at least, remaining under careful observation for several years. Some physicians treat syphilis without even mentioning to their patients the name of the disease. Except in the case of innocent wives, to whom ignorance may prove blissful avoidance of a family jar, the custom can only be condemned, for without a knowledge of the contagious nature of the disease it may be readily conveyed to members of the family, or others. When mucous patches occur upon the lips a simple kiss may convey the disease. I have known four members of one family to contract syphilis in this innocent manner.

Some patients of a reckless disposition need to be seriously admonished as to the gravity of the disease, its possible dangers, and the necessity of submitting to a more or less prolonged treatment after the early symptoms have disappeared. Such patients are often willing, and even anxious, to

take ten times the amount of medicine necessary during the persistence of an eruption, but are inclined to discontinue treatment just as soon as this has gone. On the other hand, many patients contracting syphilis are unduly alarmed, and, like children in the dark, quake at terrible evils which are by no means probable and scarcely possible. Such patients need to be soothed by assurances that the disease will run its slow course without interfering seriously, if at all, with their health, business, or pleasure, provided they keep cheerful and follow simple directions. In some cases syphilis may, indeed, prove to be a blessing in disguise. A reckless and dissipated young man, after contracting the disease, will sometimes appreciate the necessity of leading a sober life in order to get well, and will be actually healthier, happier, and possibly will live longer than if he had never been so unfortunate as to become infected.

In the treatment of constitutional syphilis, mercury is the chief remedy. While of value at every period in the course of the disease, in early syphilis it is the mainstay of treatment. It will lessen the manifestations and shorten the course of syphilis in the majority of cases. And yet it is not absolutely essential to the cure of the disease, as many imagine, for cases will get well by virtue of the *vis medicatrix*, even when no mercury is administered. The physician who believes that improvement is wholly dependent upon the drugs administered—and this belief is by far too common—is apt to neglect the hygienic and tonic measures which are of the utmost importance, and thereby to do great injustice to his patient.

The best effect of mercury in the treatment of syphilis can be obtained by the use of smaller doses than are commonly employed. From the time when the beneficial effect of this drug was estimated by the pints of saliva which dribbled from the patient's mouth there has been a constant tendency toward a diminution of the dose. Even now too many physicians are disposed to push the remedy in every case as far as possible without producing actual salivation. This common practice frequently does more harm than good.

The protiodide of mercury is a preparation in common use, and while it may not be more efficacious than blue mass or mercury with chalk,

which some prefer, it certainly possesses the most desirable qualities. In the form of tablets made of a milk-sugar trituration, it is conveniently prescribed, and in doses varying from one-eighth to one-fourth of a grain, three or four times daily, it seldom produces any gastro-intestinal irritation. When ulcerations or mucous patches are present in the throat or oral cavity the tablets dissolved in the mouth produce a local as well as a general effect, and are far superior to coated pills.

The duration of the mercurial treatment depends upon the severity of the case. The statement that syphilis should be treated two, three-and-a-half, four, or any number of years is quite as arbitrary as to say that every case of measles should be treated one, two, or six weeks. In the early period of syphilis it is advisable to continue the use of mercury for several months after the last symptom has yielded. During a relapse it should be given again, and continued for several weeks after an apparent cure. In late syphilis it need only be given until the eruption or other symptom of the disease has disappeared.

The inunction of mercurial ointment in the treatment of syphilis is certainly efficacious, but its effect is not always easy to control and severe salivation may unexpectedly occur. While the use of ammoniated mercury ointment upon the face and hands is often advisable to hasten the disappearance of a disfiguring eruption, and the application of mercurial plaster is beneficial to all syphilitic ulcers, the use of inunctions in the systematic treatment of constitutional syphilis is an extremely disagreeable method, which is as unnecessary as it is undesirable in the great majority of cases. The same remark will apply with equal force to the treatment by vapor baths and hypodermic injections.

Iodide of potassium is another remedy of great value. In early syphilis it relieves the cephalalgia and arthritic pains far more quickly than mercury, and in late syphilis it is indispensable in the removal of gummatous deposits and the healing of ulcerations. Large doses are sometimes required, especially in cases of cerebral syphilis, but usually they are unnecessary, and when continued for months are likely to do more harm than good.

SYPHILIS HEREDITARIA.—Inherited syphilis frequently causes the death of the fetus or appears in the form of an eruption at birth. In many cases the symptoms of the inherited disease do not manifest themselves for several months. The eruption upon the skin and mucous membranes, though differing in many respects from that caused by the acquired disease in adult life, is quite as characteristic. It is usually macular, papular, or bullous, and is especially apt to affect the face, palms, soles, and genital region. Extreme emaciation and an obstruction of the respiratory passages, which gives rise to a peculiar coryza, or "snuffles," are characteristic features which usually accompany the eruption. When the child is able to survive the intensity of the attack and does not succumb to some intercurrent disease, it is liable to suffer from affections of the bones and internal organs.

The inherited disease frequently manifests itself in a peculiar growth of the teeth during the second dentition. The upper central incisors are small, convergent, and notched at the free border.

In the treatment of hereditary syphilis, mercury is of the greatest value, and may be given by the mouth or in the form of inunction. It matters little whether calomel, the protiodide, or mercury with chalk is selected, but great care must be exercised in watching its effect lest gastro-intestinal irritation be occasioned and thereby increase the malnutrition. The dose should be small to begin with and gradually increased if well borne by the infant. The protiodide may be given at first in a dose of one-twentieth of a grain in a milk-sugar trituration. Calomel may be given in one-tenth, or the gray powder in one-fifth, of a grain three times daily.

In using mercury by inunction, the best plan is to rub a mass of mercurial ointment, of the size of a large pea or cherry, upon a flannel or chamois-skin strip, and bind it around the abdomen, chest, or extremities. The location of the binder can be changed from day to day to avoid local irritation.

In addition to the specific treatment, care should be taken that the child gets all the nourishment possible, has plenty of fresh air, and, in most cases, the syrup of the iodide of iron and cod-liver oil.

TRICHOPHYTOSIS

Trichophytosis, or ringworm, is a disease resulting from the growth of a vegetable organism in the hair roots and follicles, and also upon non-hairy parts, including the nails. Since the discovery of the trichophyton, in 1844, this fungus has been considered as the sole cause of all cases of ringworm, but during the past decade, careful research has discovered that the microsporon Audouini is the cause of a large proportion of cases, especially those which involve the scalp in children. Important as these observations are from a purely scientific point of view, they have not as yet served any practical purpose in the classification or the treatment of cases of ringworm. The disease is highly contagious and affects domestic animals, from whom it may sometimes be contracted. Trichophytosis presents certain clinical peculiarities according to its location, and it is therefore convenient to consider the disease as it occurs upon the scalp, the beard, the hairless skin, and the nails.

TRICHOPHYTOSIS CAPITIS.—Ringworm of the head, or *tinea trichophytina tonsurans*, as it is called by those who prefer an unnecessarily long name, is a highly contagious disease, occurring, so far as my experience goes, exclusively in youth. In schools and asylums it is often epidemic, and though never fatal, it is more to be dreaded than measles or scarlet fever, owing to its chronicity and the difficulty of effecting a cure when it has existed for a long time.

When first noticed there is usually one or more small round patches upon which the hairs are broken close to the scalp. These partially bald patches are covered with fine granular scales and present a whitish powdery appearance. In neglected cases, patches of large size and irregular shape may exist, with evidence of inflammation, and at times the parasitic disease will be obscured by the presence of a secondary eczema. In rare cases, a number of hemispherical painful tumors may appear in a group and constitute the kerionic form of ringworm. These tumors often fluctuate and appear like abscesses, but their contents are of a thick viscid consistence and cannot

be evacuated by lancing. Occasionally ringworm occurs upon the scalp in a disseminated form and presents many small scaly spots without much apparent loss of hair at the outset. This form is very apt to be mistaken for pityriasis or eczema, and the child allowed to remain in school and spread the disease among many other scholars.

The treatment of trichophytosis *capitis* should always be regarded as a most serious matter. In cases of recent development a cure is not easy, while in chronic cases it can only be obtained by the most skilful and persistent management of the patient. When we consider the time, trouble, and expense often involved in getting rid of ringworm of the scalp, the custom of many physicians who carelessly prescribe and allow a patient to infect others, through his neglect or inefficient treatment, can only be characterized as criminal malpractice.

The main object of treatment is the complete destruction of the fungus which causes the disease. While in ringworm of non-hairy parts this is a very simple matter, it is quite another thing when the spores have found their way into the depths of the hair follicles beyond the reach of ointments. A host of parasiticide remedies too numerous to mention has been recommended for ringworm of the scalp. Any one of the number may be serviceable, but the question as to which shall be used in the treatment of a case is by no means as important as the question of how it shall be used. Thoroughness and persistence in treatment are the elements of success. In order that the parasiticide application may prove efficient, frequent and vigorous shampooing of the child's head is necessary. In chronic, obstinate cases this should be performed daily. In spite of the bother it entails it will save time and trouble in the end.

As the number of parasiticides which have been recommended in the treatment of ringworm is so large, I will only mention those from which I have obtained the best results. They are salicylic acid, chrysarobin, and iodine.

In the treatment of all cases of ringworm a salicylated oil of about three per cent. strength can be used to advantage. If rubbed thoroughly into

the scalp every day in disseminate ringworm it will check the spread of the disease and render it less likely to infect the playmates of the affected child. In isolated chronic patches an ointment of salicylic acid in lanolin (ten to fifteen per cent.) may be well rubbed into the affected scalp two or three times a day with excellent effect. A very common mistake made in the treatment of this disease is the application of a remedy but once a day. The spores multiply rapidly, and if the time between inunctions is prolonged, the effect of treatment will only be to hold the disease in check, and not to effect a cure.

Chrysarobin ointment, varying from four to thirty per cent. in strength, according to the extent of surface involved, I have used for many years with satisfaction in the children's ward of the Skin and Cancer Hospital. It produces a much deeper effect than do most other parasiticide remedies. While a lotion of bichloride of mercury quickly kills the parasite upon the surface of the scalp, it does not penetrate the follicles and destroy the deeper spores as readily as does the chrysarobin ointment.

In my service at the Vanderbilt Clinic Dr. Jackson has found that ambulant cases can best be treated by a solution of iodine crystals in goose grease (fifteen to twenty-five per cent.). This remedy sinks readily into the skin, and when frequently and vigorously applied will effect a cure in the shortest possible time.

Epilation is of service in all cases of ringworm of the scalp, except those of a recent and superficial character. In chronic cases a cure can scarcely be obtained by parasiticide applications without the aid of epilation, and certainly not in so short a time. The pitch plaster and the epilating sticks are seldom used twice, as the former is extremely painful and the latter cannot compare in efficacy with the forceps. This instrument should be made of but two pieces of light metal with broad, square ends. Most of the imported epilating forceps are by far too large and clumsy, and owing to the stiffness of the blades the fingers of the user soon become tired. If the hairs are firmly grasped by the forceps and pulled quickly in the direction of their growth but little pain is occasioned.

TRICHOPHYTOSIS BARBÆ.—Ringworm of the bearded portion of the face is commonly known as “barber’s itch,” since it is usually contracted in a barber’s shop, and indirectly from some previous customer suffering with the disease. It is claimed that light-haired men are more apt to become infected than those with dark hair.

Its clinical appearance is at first suggestive of a mild squamous eczema, but the annular form which the patches usually assume, suggests the nature of the eruption. Occasionally superficial pustules resulting from intense folliculitis may be present, and the diagnosis of sycosis is suggested. Indeed, the irritation of the hair follicles from the trichophytic fungus may produce an actual sycosis, and in such a case we have two distinct afflictions to deal with.

Frequently the disease assumes the kerionic form, and in place of flat, scaly discs, an aggregation of suppurating tubercles, or a painful semi-globular tumor may be noted upon the jaw or neck. When the disease has been treated and only partly cured, it may be found extending after the lapse of a few months in the form of a reddened, curving line down the sides of the neck and on the chest. Such a case may be suggestive of a serpiginous syphilide.

The treatment of ringworm of the beard is a simple matter in recent cases, and when little inflammation is excited by the fungus. The face should be cleanly shaven every day and a sulphur or mercurial ointment rubbed into the patches morning, noon, and night.

When the patches are highly inflamed and covered with crusts, the latter may be softened and removed by rubbing the chin frequently with salicylated oil (five per cent.), or bathing it with hot water saturated with hyposulphite of sodium. When the disease is of long standing and obstinate, twenty per cent. of iodine crystals in goose grease may be rubbed thoroughly into the patches two or three times a day.

In the kerionic form of the disease, or when a number of sycotic pustules are present, the epilating forceps should be used and the skin powdered with boric acid or precipitated sulphur.

TRICHOPHYTOSIS CORPORIS.—Ringworm of the body appears at first as a small scaly disc, but soon exhibits its characteristic peculiarity of healing in the centre while spreading at the margin of the patch. In rare cases concentric rings may be formed. Occasionally a line of minute vesicles may be noted at the margin of a recent patch of ringworm, but these quickly dry and become transformed into branny scales. The eruption is most frequently noted upon the face, neck, and hands, but it may also occur upon the covered portions of the body. In certain tropical regions ringworm or a somewhat similar, if not identical, affection may occur in the form of concentric scaly rings, and occasion great discomfort.

The treatment of ringworm of non-hairy parts is as simple as that of ringworm of the scalp is difficult. Any irritating application which will cause a desquamation of the epidermis will suffice to remove the spores and mycelium. Of the many remedies which have been successfully employed, the simplest, and in my experience the best, is painting the patch with diluted or pure carbolic acid. One application will often suffice to effect a cure. A bichloride of mercury solution (one or two per cent.) painted over the patch repeatedly, or the application of chrysarobin (ten per cent.) in a solution of gutta percha, will produce the same result.

As these irritating applications sometimes occasion a severe dermatitis upon a delicate skin, they should be used with caution and, as a rule, applied by the physician instead of being entrusted to the patient. When necessary, the application may be followed by a soothing ointment or lotion.

TRICHOPHYTOSIS UNGUIUM.—Sometimes ringworm occasions a malnutrition of the nails, which become dry, roughened, and broken. Without a microscopical examination of some scrapings it is often difficult to distinguish this parasitic nail disease from a somewhat similar condition noted in psoriasis and occurring also as the result of a trophoneurosis. When but one or two nails are affected, it is always well to suspect a parasitic origin. When the fungus is discovered it can best be destroyed by brushing the nail thoroughly with soap and hot water, and then immersing the finger for several minutes in a corrosive sublimate solution of one per cent. strength.

URTICARIA

URTICARIA is a disease in which certain peculiar lesions called "wheals" appear suddenly with or without apparent cause, and after a brief duration disappear almost as suddenly as they came. A single outbreak of these wheals may constitute the whole of the attack, but generally they appear in successive crops, and the affection may assume a chronic form.

The exciting causes of urticaria consist in certain forms of irritation of the terminal nerves acting either within or without the body. How these irritants act is a question not always easy to answer, but that the relation which they bear to the eruption is one of cause and effect is often evident to the most careless observer.

The external causes of the eruption may be of a vegetable, animal, mechanical, or meteorological nature. The contact of the skin with certain species of urtica or nettle (*U. urens* and *U. dioica*) is the most evident of all the external causes of urticaria or nettle-rash, and the one which has given to the disease both its scientific and its popular name. The stinging power which the nettle exerts is said to reside in minute tubular hairs or prickles, which transmit a venomous fluid when pressed. The healthy skin is rarely, if ever, proof against the irritant action of the nettle, as it often is in the case of other poisonous plants, but in different individuals a varying degree of effect may result from its contact with the skin.

It is well known that the bites of mosquitoes, bed-bugs, fleas, and lice often evoke urticarial wheals not only at the seat of attack, but upon other portions of the body. In the case of the two latter named pests, the exciting cause of the eruption is not infrequently overlooked. Fleas are for-

tunately rare in this country, but urticaria from *pediculi corporis* may occur not only in public, but occasionally in private practice, where the cause of the trouble is very apt to pass unsuspected. The disease may also result from contact with the slimy secretion of the jelly-fish and with certain caterpillars.

That urticaria may result from mechanical causes is clear to any one who will give his skin a sharp cut with a switch, and observe the linear wheal or welt which quickly appears as a consequence (*U. factitia*). In some susceptible persons a somewhat similar lesion may be produced by the pressure or friction of wrinkled or constricting under-garments, especially those of some coarse fabric. Very many suffer from an irritable and pruritic state of the skin at the time of the autumnal change from light to heavy underwear, and a few have well developed urticaria from this cause.

Sudden changes of temperature, such as are common in spring and fall, together with a certain electric tension of the atmosphere, have been cited as causes of urticaria, and Hebra states that it is observed with special frequency whenever erysipelas prevails.

The internal causes of urticaria are more numerous than the external, and, for the most part, less susceptible of demonstration. They vary greatly in character, but are alike in producing their characteristic effect upon the skin, chiefly through the medium of reflex nervous irritation. They may be classified as dietary, medicinal, emotional, or morbid in character, and the resulting eruption must be regarded as a purely symptomatic one.

Urticaria from the use of certain articles of food (*U. ab ingestis*) usually appears in an acute form, with or without fever. In some instances, the eruption appears with a marvellous suddenness, even before the offending substance has been fairly swallowed, and from this it would seem probable that the peculiar irritation of the nerves of taste is reflected immediately to the skin, and that the eruption is not due to the absorption of the substance and its circulation through the blood. The articles of food which have been observed to produce this singular effect upon the skin, in the case of certain individuals, are eaten by others with impunity. The list of such

articles is an extensive one, and comprises fish, clams, oysters, lobsters, crabs, pork, eggs, honey, mushrooms, cucumbers, berries, fruit, etc. In a given case it may be only a single article of food which will evoke the eruption, the others mentioned being entirely innocuous. And, curiously enough, this one article will almost invariably cause an eruption, even when the person is unaware that it has been eaten.

Various drugs are liable to produce urticaria in an acute form as an incidental effect of their action. Quinine, valerian, copaiba, hyoscyamus, and chloral are the ones most likely to produce it in ordinary practice.

Urticaria from a sudden emotion, such as anger, grief, or shame, is possible, and these causes have been noted by various writers.

Disease or functional disturbance of internal organs constitutes a fruitful source of urticaria in its chronic form. The patient may believe himself or herself to be in perfect health, and it is only when the annoying eruption leads the physician to make a careful investigation of the case that the departure from health is suspected. In derangement of the gastro-intestinal canal will be found the cause of the eruption in a large proportion of cases.

It has been wisely remarked that the difficulty in curing a disease is always in direct proportion to the number of remedies used in its treatment. Urticaria is no exception to this rule. Its frequent obstinacy is attested by the experience of nearly every physician, and yet there is scarcely an affection of the skin for which so many drugs and local applications have been vaunted, tested, and discarded.

Of the treatment of acute urticaria little need be said. The cause is usually ephemeral, and a purely expectant plan of treatment, though not to be recommended, will be followed in most cases by a speedy cure. Since the eruption is so frequently due to the ingestion of irritating substances, the main indication for treatment is to evacuate the alimentary canal. The emetic which is so commonly prescribed, though rarely until after the offending substance has passed through the stomach, too often fails to remove the source of trouble, and only relieves the eruption by its tem-

porary effect upon the cutaneous circulation. In urticaria ab ingestis, particularly in children, a dose of rhubarb and magnesia or of castor oil will usually do far more good than an emetic, since the irritation which provokes the eruption is more frequently intestinal than gastric.

In acute urticaria from other causes, treatment consists almost wholly in relieving the distressing pruritus during the continuance of the attack. For this purpose, one of a great variety of soothing applications may be selected. Alcohol has proved to be a very convenient and beneficial lotion, and to obtain the best results it should be merely dabbed upon the skin with a sponge or soft cloth and allowed to evaporate, the patient being cautioned not to rub the affected parts with it. For certain patients, cologne water may be preferred, and by means of the hand atomizer, it may be applied to the skin in the form of a grateful spray. The antipruritic effect may perhaps be slightly increased by the addition of benzoic acid or sweet spirits of nitre. Acid lotions also serve to allay itching, and of these vinegar is the one which is most likely to be at hand. Rubbing the skin with a sliced lemon may likewise have a good effect. Dilute hydrocyanic acid has an established reputation as a local antipruritic, but dilute nitric acid is claimed by Startin to be quite as useful and much less expensive. A carbolized oil of varying strength is better than either.

The dependence of urticarial wheals upon contraction of the cutaneous muscular fibres, as first pointed out by Gull, would lead one to regard the local use of chloroform as of probable value, and this has been verified by experience. Sprayed upon the skin, chloroform is probably the most effective local remedy that can be used in cases of acute urticaria. I have known it to afford almost instantaneous relief in cases where the patient had been rolling and tossing on a bed for several hours, and in which the ordinary lotions used had seemingly produced no effect.

As to the employment of baths in acute urticaria there is a disagreement on the part of writers, some praising them highly and some condemning them severely on account of their alleged tendency to excite the skin. In most cases a tepid bath, containing a quarter or half pound of carbonate of

soda with boiled starch, bran, or oatmeal added, will prove soothing to the sufferer, though it may not be of sufficient benefit to warrant the trouble involved. I have repeatedly advised ambulant patients with a most intense eruption of acute urticaria to go to the nearest Turkish bath, where they have generally found speedy relief. Indeed, the eruption may disappear immediately after plunging the feet and legs in hot mustard water.

The treatment of chronic urticaria is by no means a simple matter. Expectancy will not suffice, as in the case of acute urticaria. We may wait in vain for spontaneous relief, while the torment of the patient with each recurring attack is an urgent demand that something be done, or at least attempted. Since chronic urticaria commonly depends upon functional derangement of some of the abdominal viscera, combined with an abnormal excitability of the sympathetic nervous system, our chief object in the employment of remedies should be to lessen or remove the predisposing cause, and to quiet the nervous irritability. The local applications which have been already mentioned may be resorted to as palliative measures, but to effect a cure we must depend more upon general treatment. In looking over the extensive literature of urticaria, and noting the number of drugs which have been employed in the treatment, it becomes evident that these must act in different ways, and that each one is suited only to a limited number of cases. In fact, urticaria, with its great variety of causes, is the last disease for which a specific remedy should be sought.

A very important class of remedies in the treatment of this disease are those which tend to eliminate from the blood the imperfectly oxidized products of digestion and the impurities resulting from tissue metamorphosis. The alkalies, which have such a marked effect in changing the character of the blood and in averting the attacks of gout and rheumatism, are extremely beneficial in many cases of urticaria. Bicarbonate of soda is an old and still valuable remedy, and may be advantageously given in half-drachm doses in carbonated water half an hour before each meal. Colchicum has also a beneficial action.

Since indigestion is such a common cause of urticaria, another important

class of remedies are those which allay irritation of the gastro-intestinal tract. Rhubarb in three or four-grain doses may be given before each meal to stimulate the intestinal secretions, with an occasional resort to mineral water. When gastric irritability is present, bismuth is beneficial, given in full and continued doses for a month. The administration of sulphurous acid, well diluted, will sometimes produce a speedy effect upon the eruption, probably by virtue of its action in checking the fermentative changes in the ingested food.

A third class of remedies which have been found useful in the treatment of urticaria are such as act mainly upon the nervous system and tend to lessen reflex irritability. This class comprises a considerable number of drugs, most of which have a direct influence upon the cutaneous circulation, and many of which are known to have produced an urticarial eruption. Quinine, cinchonidia, and cinchona bark, e.g., are reputed to have both caused and cured urticaria; and in many cases of intermittent fever it may be difficult to decide whether the drug or the malaria is the cause of the eruption. When the urticaria assumes an intermittent form, as is not unfrequently the case in malarial districts, quinine will, doubtless, prove a valuable remedy. At the same time the physician must bear in mind that certain patients display a peculiar intolerance of this drug, and suffer from an urticarial exanthem after a minimum dose has been administered.

Salicylate of sodium has cured some cases of urticaria, and is best administered in one or two-grain doses, repeated every hour until a physiological effect is produced. The literature of this drug, however, shows that large doses have more frequently provoked the eruption.

Belladonna and atropia, arsenic, strychnia, aconite, the bromides, ergot, pilocarpin, copaiba, and many other remedies have effected a cure, according to unimpeachable authority, but have failed signally to manifest their alleged therapeutic power in other hands, and, perhaps, if the truth were known, upon subsequent trials in the same hands. Their apparent value has undoubtedly been based partly upon faulty observation and partly upon the fact that the eruption often disappears suddenly without any treatment whatever, the unknown cause having ceased to exist.

VERRUCA

The term *verruca*, or *wart*, has been applied to various cutaneous excrescences which develop at various ages, upon various portions of the body, and present various clinical appearances. They are all hypertrophic outgrowths of the papillary and epidermic layers of the skin and of a benign character.

Verruca vulgaris, or the common wart, frequently seen upon the hands of children, usually appears as a dry, roughened, rounded growth, varying in size from a pin's head to a pea. It is often multiple, and sometimes warts may be counted upon the back of the hands and fingers by the score. In some cases they develop in the sulcus at the side of the nail and form a rough marginate patch. Upon the face the ordinary wart is apt to be conical or elongated, while upon the scalp it may appear either as a flattened growth or as a raised digitate mass of a reddened hue.

Verruca plana occurs usually upon the hands or face, and appears in the form of one or many slightly elevated and comparatively smooth growths of a faint reddish or yellowish hue.

Verruca filiformis (*acrochordon*) is most frequently seen upon the neck of middle-aged and elderly women. Threadlike pouches of skin, varying in length from one to five millimetres, are sometimes seen upon the eyelids as well as upon the neck, and look more like minute fibromata than warty growths.

Verruca senilis (*keratosis pigmentosa*) is usually seen upon the face, trunk, and hands of old persons, often in connection with pigmented spots and other evidences of senile degeneration. The tumors are usually flattened, and sometimes pedunculated. They vary in hue from a dull yellow to a dark brown, and sometimes become the seat of epithelioma, especially upon the face and back of the hand.

Verruca acuminata or *venereal wart* is a term applied to the bright red masses, of varying size and shape, which develop upon the glans penis and mucous surface of the prepuce in the male and about the vulva in the female, as the result of irritation from venereal or other secretions.

In the treatment of warts, various internal remedies have been highly recommended, among which may be mentioned arsenic, *thuja occidentalis*, nitromuriatic acid, and magnesium sulphate. I have never seen any definite results occur repeatedly from their use, and doubt if their therapeutic value is any greater than the numerous "charms" resorted to by the credulous. These certainly produce so intense an impression upon the mind in some cases as to possibly cause a change in the nutrition of the skin. Leaving out of account the untruthful and exaggerated reports of their virtues, and overlooking the numerous cases in which they utterly fail, there still remain authentic instances where a large crop of persistent warts has disappeared suddenly after recourse to one of these vulgar methods of treatment, such as dipping the hand in rain-water collected in a hollow stump, spitting on the warts with some appropriate incantation, etc.

The local treatment of warts is in most cases simple and effective. The use of acids is to be condemned, as in many cases only the projecting portion of the wart is removed, and its return speedily follows, while in other cases the acid acts too deeply and an unnecessary scar is left. When warts upon the hands are not numerous, the persistent application of a ten or twenty per cent. salicylic plaster may be conveniently used, and in time effect a cure.

The use of a small dermal curette is the best method of removing the majority of warty growths. It removes them quickly and permanently, causes but little pain when properly used, and leaves no scar. In the case of warts upon the fingers, the patient should be directed to "make a fist" in order to draw the skin tense. One or more quick scraping motions with a small sharp curette will remove the entire warty mass and leave a rounded, "punched-out" cavity in the skin. The hemorrhage, which is usually free and persistent, can best be checked by touching the bleeding surface with a cone of nitrate of silver. In the case of warty growths upon the scalp, the curette, skilfully used, will remove the excrescence without the destruction of a single hair follicle, while the application of an acid is very likely to occasion a small patch of baldness.

In warts situated at the border of a nail, the growth should first be softened by the application of acetic acid and then scraped by the curette. This may require several repetitions to remove the entire mass, especially when the patient is nervous and indisposed to bear a little pain.

The electrolytic needle has been recommended in the treatment of ordinary warts, and may be successfully employed, but in my opinion it is far inferior to the curette. In the removal of senile warts upon the back and elsewhere it may be used to advantage.

In removing the *verruca filiformis*, or soft threadlike outgrowths, from the neck or eyelid, a pair of delicate forceps and small curved scissors serve the best purpose. If slight traction be made the growth can be readily cut off at the surface of the skin, and when the minute speck of blood which may ooze out has dried and been removed the site of the excrescence can scarcely be found.

In the treatment of venereal warts the curette is likewise simple and speedy, but when patients object to any treatment of a sanguinary character, and time is not an object, the growths may be successfully removed by the use of nitric acid or equal parts of salicylic acid and starch.

VITILIGO

Vitiligo is the name applied to a partial or complete absence of pigment in one or more circumscribed patches. These are at first small and rounded, but as they increase in size they tend to coalesce and form large and irregular patches. The border of the patch is usually more or less hyperpigmented, and in many cases, especially upon the face, the darker portion of the skin is far more striking in appearance than the abnormally white spots, and an erroneous diagnosis of chloasma is sometimes made.

Vitiligo is most frequently seen upon the backs of the hands, face, and neck, but it may also occur upon covered portions of the body. In the negro it is especially common and most striking in appearance. In some cases the white patches have continued to enlarge from year to year, until

finally little or none of the normally pigmented skin has remained. In white patients the affection is far more conspicuous in summer, when the normal skin is tanned, and thereby presents a stronger contrast with the whitened patches.

The cause of vitiligo is unknown. It is held by some that it is due to a disturbance of innervation, an explanation which, as Shepherd remarks, tells us nothing, and is only a cloak to hide our ignorance, for nothing is known of its pathology.

The treatment of vitiligo is most unsatisfactory, and no remedy, either internal or external, can be said to have any notable effect. As the disease tends to spontaneous recovery in some cases, it is possible that nerve tonics combined with cold spinal douches might have a beneficial effect. Brocq suggests the use of vigorous friction or irritating applications to the spinal column, combined with electric baths, or the prolonged use of the galvanic current. Besnier recommends the subcutaneous injection of pilocarpine.

In the local treatment of vitiligo, curative remedies are lacking. Attempts have been made to increase the pigmentation of the white patches by the use of mustard and other stimulating applications which usually tend to darken the normal skin. However excellent this plan of treatment may be in theory, no satisfactory results are likely to be attained in practice. Other attempts have been made to lessen the conspicuous appearance of the white patches by treating the dark border with strong lotions of corrosive sublimate or hydrogen dioxide, as recommended in the treatment of chloasma. This plan has been productive of some temporary benefit, but not enough, so far as my experience goes, to yield much satisfaction.

Fortunately vitiligo is not an affection which involves the patient's health or comfort. If the patches upon the face are regarded as a very serious disfigurement a simple palliative measure is the use of a fine toilet powder tinted to suit the requirements of the case. A weak lotion of pyrogallic acid, or walnut juice, painted over the patches will also tend to partially conceal them, exerting a cosmetic if not a curative effect.

XANTHOMA

Xanthoma is an affection which occurs in the form of small yellowish, circumscribed patches, usually upon the eyelids (Xanthoma planum), or as an eruption of small yellowish nodules or tumors upon various portions of the body (Xanthoma tuberosum). These two forms are rarely associated, and by some writers are regarded as distinct affections. When the palms are affected, yellowish stripes are usually seen following the natural transverse furrows (Xanthoma striatum).

The cause of xanthoma is in most cases quite obscure. A tendency of the disease to affect two or more members of a family has been noted, and in many cases a history of preëxistent jaundice, or other hepatic disease, can be obtained.

In most of the cases of xanthoma occurring as a general eruption, more or less sugar has been found in the patient's urine, and some writers have been inclined to regard these cases as constituting a distinct affection (Xanthoma diabetorum). The lesions present no characteristic features which would serve to distinguish them from those seen in xanthomatous patients who do not suffer from glycosuria. The eruption in diabetic subjects, however, is apt to develop more rapidly and often to disappear spontaneously. It is somewhat inflammatory in character and responds quite readily to internal treatment.

The treatment of xanthoma of the eyelids consists in the removal of the patches either by the knife, caustics, or the electrolytic needle. When the patches are not of large size, excision by means of sharp curved scissors is certainly the speediest method of effecting a cure. When a large patch upon the upper lid, near the inner canthus, is excised, the healing of the wound is liable to produce a puckered ridge, if not a slight ectropion. The use of the thermo-cautery after the yellow patch has been drawn through an aperture in a thin sheet of asbestos paper has been suggested, but is not to be commended.

Acids, either nitric or monochloracetic, may be repeatedly applied by

means of a wooden toothpick and a successful result obtained, but electrolysis furnishes the simplest and safest method of destroying the growth. If a fine needle attached to the negative cord is inserted beneath the lax skin from one edge of the patch to the other, a weak current will suffice to destroy the tissue around the needle with very little pain, and with three or four insertions of the needle at one sitting, a patch of considerable size may be readily converted into a dark superficial crust, which will fall in the course of a few days, leaving a red mark like a slight burn in place of the yellow patch. Should any trace of the original disease be left, the point of the needle may be inserted again and the remnant destroyed. In this operation the patient should be directed to touch the moist sponge connected with the positive cord with the tip of one finger after the needle has been inserted. Gradually the other fingers may be applied, and finally, if it is necessary, the sponge may be grasped firmly in the palm. This method tends to prevent a sudden and unpleasant shock at the outset and allays the patient's fear, which usually exceeds the pain of the operation.

The tendency to the return of xanthoma palpebrarum after treatment may be due to the fact that complete removal of a patch does not prevent the development of the new growth in the neighboring skin. On the other hand, and especially when caustics are used, the destruction of the patch may be more apparent than real, and under such circumstances it speedily assumes its former yellow hue. Even the application of collodion will lessen the color of a patch for a short time. In a case recently treated, I noted the interesting fact that after a bright yellow patch had been removed by electrolysis from the left upper lid, a similar patch upon the right upper lid became spontaneously paler in hue.

In the treatment of xanthomatous nodules a strong salicylic ointment or plaster (fifteen to twenty per cent.) has proved successful in the hands of Morrow, L. Heitzman, and others. When large isolated tumors are present, and occasion considerable annoyance, their removal by the knife is advisable.

The frequent association of xanthoma with hepatic disease and glyco-

suria would naturally suggest the removal of these predisposing factors of the eruption. While little, if any, effect can be produced upon xanthoma palpebrarum or the chronic nodular eruption by any form of internal medication, the treatment of the diabetes which complicates other cases is usually followed by an immediate improvement, and often by a complete disappearance of the eruption. Dietetic measures are far more important than drugs in combating the diabetes. Besnier, who regards the xanthoma and the glycosuria as arising from the same general condition, recommends phosphorus, one-sixtieth to one hundredth of a grain daily for ten days, and then turpentine for a month, increasing the dose to two and a half drachms daily.

ZOSTER

Zoster (or *Herpes zoster*) is an acute, vesicular eruption occurring in patches which follow the course of one or more cutaneous nerves. It occurs, as a rule, upon one side of the body, and rarely affects a patient more than once. The eruption usually develops in from four to six days. The vesicles, which are then tense and filled with clear serum, gradually become purulent and flattened, and during the second week are transformed into thin crusts, which sometimes present a dark or hemorrhagic appearance. As the patches do not all develop simultaneously, some may appear in a more advanced stage than others. A burning or tingling sensation often precedes the eruption, and severe neuralgic pain usually accompanies it in advanced life. Upon the forehead the disease is apt to be most severe, and deep scars are not infrequently left in this location.

As to the nature and cause of zoster, various opinions have been expressed by those who have carefully studied the subject. Some regard it as an acute, specific, infectious disease on account of its occurring often in epidemic form in the spring and fall, running a definite course, and seldom occurring twice in the same patient. Others regard the disease as the result of a neuritis affecting either the cord, posterior spinal ganglion, or periphery of the nerve supplying the skin involved.

The eruption has been observed to occur frequently in those taking arsenic, which in toxic doses may occasion a peripheral neuritis. Tenderness of the nerve root upon the affected side of the spine can often be demonstrated, and in many cases I have elicited a history of some fall, blow, or other injury which may have caused the eruption.

In the treatment of zoster, phosphide of zinc, *nux vomica*, *gelsemium*, quinine, salicylate of soda, and other remedies have been recommended, but I have never been able to convince myself that any drug has the slightest influence upon the course of the disease. Antipyrin, phenacetin, or, better still, an injection of morphia may be used to lessen the pain and wakefulness in certain cases; but, as a rule, no internal remedy is required.

In the local treatment of zoster of the trunk, which is the most common form of the disease, a soft linen handkerchief fastened smoothly to the underclothing will protect and soothe the inflamed skin as well or better than the ointments and lotions which have been recommended. If this is thought to be too simple, a ten per cent. solution of ichthylol (Zeisler), or a ten per cent. lotion of *grindelia robusta* (Duhring), may be painted over the vesicles.

The use of collodion, either plain or containing morphia, the oil of peppermint, thymol, and other irritating applications are almost certain to add to the discomfort of the patient. A simple dusting powder will do no harm, even if it does little or no good.

A strong galvanic current applied around and between the patches by means of a metallic roller attached to the negative cord will often relieve the pain for a short time, and possibly tend to abort the eruption if it be used twice daily at the outset. In cases of ophthalmic zoster, I have found this method to prove far superior to any other local treatment, and in the persistent neuralgia which sometimes follows zoster, in elderly patients, I know of no other remedy that can take its place. For this uncomfortable sequel of zoster the application of a small blister, or the actual cautery over the spinal ganglion upon the affected side has been recommended by some as a last resort.

GENERAL CONSIDERATIONS

IN concluding this brief treatise on cutaneous therapeutics it may prove instructive to turn from individual diseases and to take a broad view of the subject. A few general considerations, based upon experience, will doubtless prove of far greater value than pages of special formulæ.

The successful treatment of skin diseases depends largely upon their causes. These are various and, in many cases, obscure, if not wholly unknown. As a study of the cure of skin diseases involves a study of their cause, it is impossible to discuss dermatological therapeutics without considering the etiology of the various diseases.

The ancient theory of a *materies morbi* existing in the system and causing disease by its cutaneous elimination, still survives in the prevalent idea that all eruptions indicate some impurity in the blood. While this may be true as applied to the exanthemata, and to those inflammatory affections which owe their origin to toxic products generated in the digestive tract, it is to irritation of the nerve centres, rather than to any poisoning of the blood, that we must look to discover the source of the symptomatic dermatoses.

While a close sympathy exists between the skin and the internal organs, and constitutional conditions, such as malaria, gout, rheumatism, and diabetes, often act as predisposing causes of cutaneous inflammation, the skin is an independent organ and may have its own local affections. Many of these are manifestly the result of thermic, traumatic, parasitic, and other external agencies. But in spite of recent bacteriological researches, and the tendency to ascribe many cutaneous ills to parasitism, it remains a fact that most skin diseases are of internal origin.

For the student of dermatological therapeutics, the first thing to learn is the great importance of treating the patient, and not merely the patient's skin. For some mysterious reason, this seems to be the hardest lesson for the

average physician to learn. In a case of measles or scarlatina no physician thinks of relying upon local remedies for the cure of the disease, although he may wisely use cocoa-butter or some other application to lessen the burning sensation of the skin or to soften and disinfect the dry and desquamating epidermis. In many other dermatoses, although they may not run a definite course like the common exanthemata, the disease is quite as far removed from the surface of the skin, and there is no more need for local treatment except in so far as it may be productive of a comforting or palliative effect. But too often, in such cases, the physician will persist in treating merely the patient's skin (either by arsenic internally or ointments locally) until the disease gets well of itself through accidental cessation of the undiscovered cause, or until he has "tried everything" and given up in despair.

The specialist is often accused of taking a narrow view of any given case, and failing to appreciate the relationship of various conditions which should enter into the question of its judicious treatment. But not infrequently his aid is sought by some physician in general practice, who has carefully studied the "medical progress" column of his favorite journal, and tried every new remedy and formula therein mentioned, with results unsatisfactory to both his patient and himself. The former has perhaps a persistent eczema dependent upon some internal cause. The case may be one requiring no *special* treatment, and, instead of dosing him with arsenic, which is likely to do harm rather than good in the majority of cases, or depending upon a frequent change of ointments for an impossible curative effect, the specialist often obtains a brilliant result, not by recourse to the special skill or knowledge he may possess, but simply by treating the case on broad general principles. In other words, he does precisely what the general practitioner might do, is presumably so well qualified to do, and which, alas! he so often fails to do through his anxiety to adopt some new and highly specialized method.

In the treatment of diseases of the skin a correct diagnosis is of prime importance. To know exactly what is to be done is essential to its speedy and successful accomplishment. But diagnosis implies something more than merely giving a correct name to a pathological condition. It involves not only

an accurate appreciation of the conditions which are present both in the skin and in the internal organs, but also a knowledge of the various causes which tend to produce these conditions. In this broad sense a perfect diagnosis of a skin disease is rarely if ever made, owing to the limitations of our medical knowledge. In the common and restricted sense of the word it is plain that two physicians may make a correct diagnosis in a given case,—*i.e.*, they may apply the same name to the eruption. But to one the diagnosis is merely a name, while to the other it is a name suggestive of morbid conditions which must be dealt with and removed before a cure can be effected. If the treatment employed by the former prove successful, the result is commonly due to a happy chance in the selection of his remedies, or to the natural tendency of the disease to recovery. If success crowns the therapeutic efforts of the latter, a certain degree of credit can be claimed for the rational employment of means to accomplish a definite purpose.

In all cases of skin disease the main factor in the production of a cure is the *vis medicatrix naturae*. There is a natural tendency manifested by nearly all eruptions to disappear under certain conditions which do not merely act upon the skin, but which influence the function of every organ of the body. In treating a skin disease, it is the first duty of the physician to restore these conditions. In the progress of modern dermatology, many valuable remedies have been added to our therapeutic armamentarium, while many more of little or no value are constantly being foisted upon the profession as a result of commercial activity on the part of manufacturing chemists. Some of these valuable remedies are capable of producing most brilliant results when used with skill and discretion, but it remains a fact that the greatest mistake which a physician is liable to make in the treatment of skin disease is the complete reliance which he so often places upon remedies, both for internal and local use.

If the physician could be induced to take a broader view of cutaneous medicine and pay less attention to the integument, his therapeutic success would be greatly enhanced. If, when he meets with an intractable case of eczema or psoriasis, he were willing to treat the case as if the patient had come to him without any skin disease whatever, seeking by various means to put him in his

best possible physical condition, he would often find that the obstinate eruption which has withstood all methods of special treatment at his command would yield spontaneously or disappear under the very remedies which he had tried in vain and pronounced of no value.

In the general treatment of a patient suffering from a disease of internal origin the main object should be to discover and remove the cause. But in many cases the precise nature and the exact location of the internal functional derangement which gives rise to an eruption are very difficult matters to determine, and often it is much easier to remove the obscure cause by measures which tend to improve the patient's general condition than to discover what and where the cause may be. All therapeutic agencies which equalize the circulation, strengthen the digestive functions, induce refreshing sleep, and improve the nutrition of the body will be found to be powerful factors in the cure of cutaneous disease. When judiciously employed, these agencies will often effect a cure even when the cause of the eruption remains undetermined, and when, perhaps, no correct diagnosis has been made. Indeed, the improvement of a patient's general health by various hygienic and medicinal agencies will often loosen the hold which an obstinate eruption seems to have upon the skin and greatly enhance the therapeutic effect of local remedies which before had seemed to be of little value.

In treating a patient with a view to improving his general condition, and thus striking at the root of many skin diseases, there are pharmacopœial remedies which render valuable service. Chief among these may be mentioned arsenic, iron, mercury, and the salts of potash and soda.

Arsenic has long held a prominent place in cutaneous therapeutics. It is regarded by many as the chief dermatological remedy and prescribed in a routine manner, as discreditable to the physician as it is injurious to the patient. That arsenic is a remedy of great value is indisputable, but its injudicious use is so common that very frequently more harm than good results.

As a nerve tonic, arsenic may improve the general condition of the patient, apart from any direct effect which it may exert upon the skin. Its action upon the mucous layer of the skin is a notable one, and in chronic or subacute affec-

tions of a superficial character its administration may prove most satisfactory. In a highly inflamed condition of the skin, it is very apt to increase the congestion and to augment the heat or pruritus from which the patient suffers.

In psoriasis and eczema arsenic often proves of service in removing chronic localized patches and in hastening the disappearance of an extensive eruption when this has reached its period of decline. In pemphigus it has been lauded as a specific, and while it may in some cases exert a brilliant effect in curing the eruption or in preventing its return, in many other cases it will be found of little or no value. In acne, urticaria, lichen planus, furunculosis, and other diseases in which it has been highly recommended and frequently prescribed, its value is questionable, while its liability to produce gastric irritation is certain.

The liquor potassi arsenitis, or "Fowler's solution," is the remedy most commonly prescribed, but as this is a complex and unstable preparation the physician will act wisely who throws off the shackles of habit and prescribes in its stead the liquor arsenici chloridi, which is of the same strength.

Iron is a remedy which is rarely associated with any particular skin disease, except it be erysipelas, for which it is usually prescribed more in deference to custom than from any evidence of its virtue. Indirectly it may prove of great value, however, since in many patients a condition of marked anaemia exists to which attention must be paid before any good result can be justly expected from local treatment.

Mercury is of such inestimable value in the treatment of syphilis, either alone or combined with potassium iodide, that one is very apt to overlook the advantage to be derived from the use of these drugs in the treatment of non-syphilitic affections. Nevertheless, there are few diseases of a chronic inflammatory nature which will not show an improvement when subjected to the influence of these potent remedies; and this improvement is by no means to be considered as evidence that the patient is the victim of a syphilitic taint. Psoriasis, lichen planus, leprosy, and certain forms of malignant disease will often respond to the ordinary "anti-syphilitic" treatment, although the improvement may be but slight and temporary.

The alkaline diuretics and purgatives play an important part in the treat-

ment of all inflammatory eruptions, lessening the intense congestion of the skin and thereby enhancing the value of local remedies. Instead of prescribing potassium citrate three times a day, or a morning dose of sodium phosphate, it is an excellent plan, when feasible, to have the patient take the same amount in divided doses, each in a full glass of water, at intervals of one or two hours.

But, while drugs may accomplish much in the way of toning up the system of a patient with skin disease, improving the digestion, and facilitating the elimination of waste products, it must not be forgotten that there are remedies outside of any pharmacopœia which will accomplish the same purpose, and often with much greater celerity and directness. Indeed, there are few, if any, prescriptions which, in the treatment of a rebellious skin disease, will accomplish as much as systematic bathing, exercise, and diet. Theoretically every physician professes to be a strong advocate of these measures, but in actual practice very few succeed in impressing upon the patient's mind an adequate sense of their importance. Good advice is not infrequently given as an accompaniment of the Latin prescription, but no pains are commonly taken to see that the advice is acted upon. Not only in the treatment of skin diseases, but in many other ills for which medical advice is sought, both physician and patient are prone to rely in great part, if not wholly, upon an exclusive medicinal treatment, and both in the profession and among the laity the idea seems to be as prevalent as it is erroneous that for the cure of every ill a Latin prescription is absolutely essential.

It is a severe reflection upon the medical practice of the present day, but it is nevertheless a fact, and one well worthy of thoughtful consideration, that many patients suffering from chronic eczema and psoriasis would recover sooner under the strict regimen of an athletic trainer than in the hands of an inveterate pharmacophile, whose idea of cutaneous therapeutics has never reached beyond the narrow confines of Fowler's solution and a frequent change of ointments. While pharmacopœial remedies and hygienic measures may be satisfactorily combined in the treatment of most cases of skin disease, it is by far too common a mistake to rely upon the former and to regard the latter as an unimportant adjuvant.

Bathing is a remedy which in cutaneous therapeutics should be esteemed on account of its prophylactic rather than its curative power. A daily bath invigorates both mind and body, quickens and equalizes the circulation of blood, stimulates the functional activity of the whole integument, and renders it far less liable to become the seat of pathological processes. Incidentally it has a cleansing effect upon the surface of the skin, but this is of comparatively little importance. The main object of a bath is to refresh and invigorate, not merely to cleanse. A normally active skin was designed by Nature to keep itself in a healthy condition, even without bathing, and the common talk about a bath being necessary to open the pores of the skin and allow excrementitious matter to escape has no more basis than many other absurd ideas gleaned from medical almanac pathology. It is normal perspiration that keeps the skin proper in a cleanly condition, and though soap and water may be advisable to improve the condition of the surface, it is certain that a man who works hard and perspires freely will have a far healthier and a really cleaner skin than he who eats heartily and leads a sedentary life, even though he may scrub continuously. In short, the great benefit which is unmistakably derived from a daily bath is attributable, not to its cleansing properties, but to its stimulant effect upon the nervous system.

Baths may be thermometrically classified as hot (98° and over), warm (90° – 98°), tepid (85° – 90°), cool (65° – 85°), and cold (65° and less). Each of these may prove advantageous in individual cases, and under certain conditions; but for the great majority of persons in health, or suffering from no serious disease, the cool bath taken every morning is capable of producing the greatest benefit.

Exercise exerts indirectly a beneficial effect upon skin diseases by improving the general condition of the patient. In some cases it may temporarily increase his discomfort, but in the end will do far more good than harm. Private patients are often kept in bed and worried by frequent and painful change of dressings which fail to effect a cure, when perhaps this could be readily accomplished by simply using vaseline or some dusting

powder on the affected skin, and insisting upon the patient dressing, and at least taking a drive if not a walk in the open air. In our dispensaries, the physician in charge finds it more convenient and more in accordance with the ideas of the patients to prescribe rhubarb and soda, and this or that ointment, than to spend time in regulating the diet and insisting upon out-of-door exercise. But in the great majority of dispensary patients, especially women, improper diet and household confinement are the principal causes of the eruption, and here, as in many other cases, the best and speediest results may be obtained by simply removing these causes.

In the case of clerks and shop-girls, with long hours of work and little time for play, it is difficult to get much out-of-door exercise; but when "tonics" have lost their effect and local remedies have failed to remove an eruption, the necessity for a little breathing spell every day is obvious, and more exercise in the open air becomes imperative.

Exercise is rarely thought of as a dermatological remedy, and few, if any, writers on cutaneous therapeutics ever condescend to mention it. And yet there is a large class of skin diseases in which systematic daily exercise of a more or less vigorous character will accomplish far more than a whole pharmacopœia. With few exceptions, all skin diseases, and particularly those of an inflammatory character, tend to spontaneous recovery when the patient is in a normal condition, so far as the functions of other organs are concerned. Nearly every obstinate case of eczema or psoriasis can be certainly and speedily cured by any judicious trainer, with no medical knowledge, if the patient is only willing to live and act as he would have to do in case he wished to distinguish himself in some athletic contest. A man ready to enter a prize-fight or a boat-race always has his skin in that perfectly normal state in which Nature intended it to remain, and from which it so often becomes perverted by improper habits of life. Why, then, should we not learn a lesson from the tactics of the trainer? When the physician meets with an obstinate case of skin disease which refuses to yield to arsenic and ointments, why should he not give up his cherished *secundum artem* treatment and assume the more successful rôle of an intelligent medical

trainer? Of course it is not essential to pound a sand-bag or to row a boat in order to gain strength and health. Although many a sufferer from chronic skin disease would willingly adopt the most rigid course of training in order to secure a healthy skin, there are simpler and pleasanter forms of exercise which, combined with a strict diet, will accomplish the result. The patient need not be required to enter either a fight or a race, but if he is thoroughly prepared to do either, he will doubtless find that the chronic skin disease has disappeared in the process of preparation.

In the treatment of skin diseases there is nothing more important than regulation of the diet. Since many eruptions depend wholly or in great part upon dietetic errors, it is very evident that judicious advice as to what should be eaten, and when and how it is to be eaten, is much more certain to strike at the root of the trouble than the common custom of prescribing antidyspeptic remedies. If a patient is accustomed to indulge freely in pie, cabbage, candy, or whatever may tend to induce a foul stomach, intestinal fermentation, and an irritable skin, it is conventional to prescribe pepsin, bismuth, or some other antidote. It is common sense to say, "Stop it." While the importance of dietetic restrictions is generally admitted, there is a lamentable lack of unanimity among physicians as to what rules are best suited to patients in general, and as to what plan of diet should be adopted in any given case. In fact, the question of diet in skin diseases is one which has heretofore received but little attention, though offering an attractive field for careful observation and scientific research. Many time-honored notions as to the value or detrimental qualities of certain articles of food prevailing among the laity are accepted and acted upon by the profession, and rarely is any attempt made to ascertain by experience whether fact or fancy is the basis of these views. With this lack of definite knowledge in the domain of dietetics, and the frequent occurrence of idiosyncrasies which prevent patients from eating the very things that would, theoretically, be best for them, it is difficult to lay down positive rules applicable to all cases, but the following suggestions, based upon experience, may prove of more or less value:

An occasional change of diet is essential. There is no more reason for

living on the same food the whole year round than there is for wearing the same clothing, and much more discomfort, if not positive harm, is likely to result from so doing. An abundance of beef, like a fur overcoat, may be very desirable in this climate on New Year's Day, but decidedly unseasonable on the Fourth of July.

The "spring fever," or that feeling of lassitude which so often comes with the early warm days, and suggests to so many the necessity of medicine "to purify the blood," is simply an indication for a change not only of clothing, but of diet. During the brief season when fresh garden vegetables can be readily obtained, and later, when perfectly ripe fruit is abundant in the market, it seems almost a shame for any one to eat the food which can be had at any time and to neglect that which at other seasons is so difficult to secure. A change of diet is often beneficial, even if it be from a good to a bad diet, or what might be so considered. Nearly every inflammatory disease of the skin is greatly aggravated, if indeed it is not primarily caused, by the dietetic habits of the patient. The physician may be wholly unable to determine just what article of food is most responsible for the cutaneous trouble, or just where to look for the loose screw in the digestive apparatus which prevents the proper assimilation of food that others can eat with impunity. He is justified, however, in assuming that some article of food or dietetic habit may possibly cause the eruption, and hence a radical and even empirical change in the diet, although it may sometimes do harm, will in a large number of cases be followed by the best results. If the patient has been a large eater of meat, let him join the vegetarians for a limited time; while, on the other hand, if he has taken little or no meat and a little of everything within reach, let him try the effect of an exclusive beefsteak and hot water diet. Although this latter plan of dieting, so popular with a few physicians, is about the last that should be recommended for long-continued use, it is often extremely valuable for a few days or weeks, and will frequently cleanse a coated tongue, sweeten a foul stomach, and lead to the disappearance of many derangements and disorders, including some which affect the skin. Although the ordinary stomach will tolerate an exclusive meat diet

more readily than a purely vegetable one, the latter seems in general more conducive to a healthy state of the skin. For instance, a patient with chronic psoriasis will invariably note the fact that the scaly disks upon his body are more apt to look red and angry and to increase in size when he is partaking freely of meat. And in acne, eczema, and other diseases the dreaded oatmeal and buckwheat cakes may not do half the harm so often caused by a too highly nitrogenous diet. But while the vegetarian and the carnivorous advocate continue to wage their wordy warfare, the patient with a chronic skin disease will find that a change from one to the other will be more beneficial than a strict adherence to either doctrine.

A rigid restriction of diet is often as important as a change. While it is true that "the board kills more than the sword," and that we all eat many things which we do not need, if not absolutely more than we need, it should be understood that a restricted diet does not necessarily imply a scanty or starvation diet. Many patients with skin disease eat heartily, exercise but little, and are too well nourished. The first step in the treatment of such is to reduce the weight five, ten, or perhaps twenty pounds. The ointments and lotions which at first have little or no effect often act like magic when this is accomplished. But many other patients with skin disease are thin and weak and nervous, and demand an opposite plan of treatment. Until the general condition of such patients is greatly improved, as indicated by a decided increase in weight, no treatment can be expected to cure the cutaneous disorder. These patients cannot afford to eat everything which they happen to fancy. Their diet should be restricted to those articles alone which will tend to make flesh and blood. Medicinal tonics are often a delusion and a snare when nourishment is all that is required.

How the diet may best be restricted is a problem often difficult to solve. The common advice to eat no shell-fish, no pastry, no fried articles of food, or no sweets may be judicious, but it rarely accomplishes any curative result. Because shell-fish, strawberries, or starchy food are productive of harm in certain cases, there is no valid reason why all patients should be subjected to their routine prohibition, and certainly no reason why the physician should be

content with this limited restriction when there are many other edibles in a given case which are quite as likely to do harm.

Patients often declare that they eat no sweets nor starchy foods with a pharisaical air which plainly intimates their belief that such a meagre restriction is a clear title to health and happiness. While there are some who do suffer from amylaceous indigestion, many patients with skin disease can eat starch and sugar with impunity, and doubtless would be better off were they to avoid a great variety of made dishes and for a short time live simply on good bread and butter and plain cake. This proscription of sugar and starch is based largely on the theoretical assumption that most patients suffer from gout, and that many skin diseases result therefrom. This is one of the current medical fads. Twenty years ago nearly every man who failed to follow the simplest hygienic laws and felt at times more or less miserable was informed by his physician that he had malaria. Now the same patient under similar circumstances is gravely told that he is gouty, and that his salvation depends upon the avoidance of sweets.

If sugar and starch in any given case are found by experience to do harm, they should be forbidden ; but this is not going far enough. Other dietetic habits of the patient, of which the physician often remains in ignorance, are liable to do much more harm. It is advisable, therefore, not to say to a patient, "Don't eat this or that," but to tell him simply what he may eat, and then see that this regimen is strictly enforced.

For a few days the more restricted the diet the better, and gradually more articles can be added to the list. By this method a definite idea can be formed as to what food is injurious and what can be taken with benefit.

The internal use of water in the treatment of skin diseases is quite as important as its external use. Indeed, if water were a very scarce commodity it would doubtless be more beneficial to renounce bathing than to limit the supply for internal use. Drinking freely of pure water every day tends not only to improve digestion, but facilitates the functions of nearly every organ and does far more to keep the skin in normal condition than is generally imagined. Taken frequently in copious draughts, it will wash

out the stomach as thoroughly as by lavage, if not as speedily. It will tend to clear a coated tongue and regulate the bowels as no single remedy of the Pharmacopœia can possibly do. It will remove the lithæmic condition upon which many skin diseases depend, and by striking at the root of the trouble will effect a permanent improvement which could not be expected from any external application.

In prescribing this valuable remedy it is often of little use to simply advise the patient to drink freely. A definite number of glasses should be ordered, amounting to two quarts, more or less, if good results are expected. This amount should be taken in small doses frequently repeated and upon an empty stomach, inasmuch as too much fluid with meals is very apt to impair their digestion. In catarrhal conditions of the stomach, the sipping of hot water (not warm water) a half-hour before each meal is often of great benefit, and in cold weather a frequent hot drink greatly promotes the activity of the circulation and thereby improves the condition of the skin. For those who acquire a distaste for the plain hot water, a little salt or lemon or other flavoring can be employed to advantage; but if the water is as hot as can be taken by a spoon it is seldom apt to nauseate as is the case with warm or tepid water.

The free use of most bottled waters is recommended when patients object to the inexpensiveness or occasional impurity of Croton or other city waters; but it is the water which does the good, whether it comes from a bottle or a pipe. Most of the lithia waters on the market have no special advantage over plain water, in spite of their numerous testimonials, and some contain very little lithia, notwithstanding their name.

Many of the waters bottled at springs in various parts of the country are erroneously supposed to possess marvellous therapeutic properties. With the exception of the sulphur and saline waters, most of them are wholly devoid of special virtue not inherent in any good and reasonably pure water. When the product of these springs has been bottled for many months before reaching its final destination, it is very apt to have lost its freshness and original flavor. Unlike wine, water does not improve by age, and

should therefore be expressed from the spring to the consumer with the utmost speed and directness.

These suggestions as to the general treatment of a patient, irrespective of the local affection which leads him to consult the physician, are applicable not only to patients with cutaneous disease, but to very many others whose cases call for the exhibition of sound common sense rather than any special medical skill. Indeed, it is a question whether dermatology should be regarded as a specialty. Unlike ophthalmology or laryngology, it does not call for any expertness in the use of instruments which the general physician is not expected to possess, except in a few cases which properly come within the domain of surgery.

Dermatology is simply a branch of general medicine, and every practising physician should be competent to treat almost any case of skin disease, provided he possesses the skill and experience which are requisite to make a correct diagnosis. Diseases of the skin do not constitute a specialty any more than do diseases of the stomach or diseases of the lungs. Success in their treatment does not depend so much upon *special* knowledge as upon experience, sound judgment, common sense, and the application of those general principles of medical science which every physician is supposed to possess. The physician in general practice often makes a great mistake in thinking that he must employ some special remedy in every case of skin disease, and is very prone to select the latest therapeutic novelty mentioned in the medical journals. In so doing he is very apt to forget the simple, and perhaps old-fashioned, measures which would certainly improve the patient's general condition, and to discard the remedies of which he has had some experience, and which in his hands would doubtless prove far more effective than the new and untried methods, the name of which is legion.

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PLATE LXXIII.

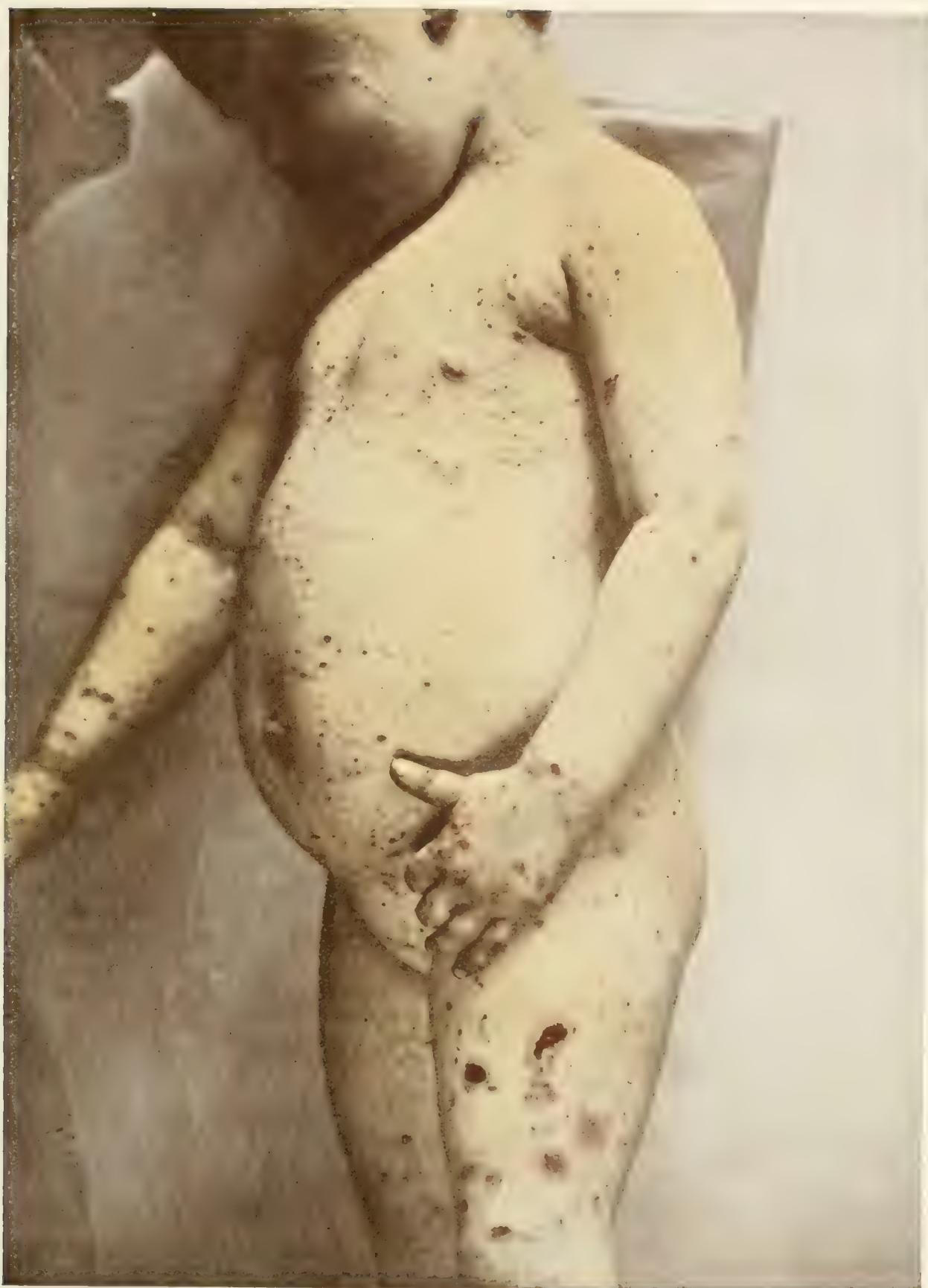
SCABIES

SCABIES

The eruption in a case of scabies is mainly artificial and results from the free use of the finger-nails. It may consist merely of excoriations, but in many cases, owing to the vulnerability of the skin, a secondary eruption of an eczematous type with papules, vesicles and pustules is induced. When, in addition to this, local infection of the numerous scratch marks occurs, ecthymatous crusts and superficial ulcerations are frequently seen.

The eruption in scabies often bears a close resemblance to a papular eczema and may indeed be justly regarded as such an eruption evoked by external irritation. The diagnosis of scabies, however, may be readily made by noting the characteristic location of the eruption. When excoriated papules or other lesions are numerous upon the web of the fingers, the anterior aspect of the wrists, the axillary region, the female breasts, or about the genitals in men and boys, the parasitic origin of the eruption is invariably indicated.

The little girl portrayed in the accompanying plate had suffered from scabies for several weeks and presented an unusually extensive eruption. There were numerous pustules as well as excoriated papules upon both the trunk and extremities and a few ecthymatous lesions upon the thigh. The free use of sulphur powder quickly allayed the intense itching and the skin was soon as smooth as ever. At the same time care was taken to have the other children in the family submitted to the same treatment.



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SCABIES.

PLATE LXXIV.

SCROFULODERMA

SCROFULODERMA

Although the term scrofula has always had a somewhat vague significance and various skin diseases have been attributed to its influence, the name scrofuloderma has a more precise meaning. It is applied to chronic suppurative inflammation occurring in strumous or tuberculous subjects, and usually in connection with glandular inflammation of the neck or elsewhere. Though often classed as a form of cutaneous tuberculosis, it presents clinical features which differentiate it from the common forms of this disease. In place of the small nodules which are characteristic of *lupus vulgaris* and the papillomatous growth found in cases of *tuberculosis verrucosa*, we have in scrofuloderma an indolent undermining ulceration of the skin with more or less of crusting, and a marked tendency to the formation of reticulated or puckered cicatrices.

The subject of the accompanying portrait, a boy aged twelve, of German parentage, was brought to the Vanderbilt Clinic by Dr. H. J. Wallhauser. There was no evidence in the case of inherited tuberculosis, and the ulceration of the cheek and neck was attributed to a fall when four years of age. From this time the boy had been in delicate health, and extensive ulceration had occurred upon either side of face and near the elbows. He had suffered also from a dactylitis of the right index finger. The large patch upon the right cheek began as a suppurating tumor and the resulting ulceration pursued a characteristic indolent and obstinate course, extending up beneath the eyelid and down across the anterior surface of the neck. The illustration shows an ectropion of the lower eyelid and a slight deformity of the ear, produced by partial cicatrization.



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SCROFULODERMA.

PLATE LXXV.

SCROFULODERMA
LUPUS VULGARIS

SYPHILODERMA
EPITHELIOMA

SCROFULODERMA
LUPUS VULGARIS

SYPHILODERMA
EPITHELIOMA

The four distinct affections shown in the accompanying plate are grouped on account of their appearing upon the same region of the body.

In the first illustration is seen an indolent inflammation of several lymphatic glands and of the overlying skin, which was formerly regarded as a manifestation of the "scrofulous diathesis." This condition is now regarded as usually if not invariably the result of tuberculous infection, although tubercle bacilli are not always found upon microscopic examination of the tissues. The ulcers undermining the skin and producing puckered cicatrices are quite characteristic.

The second illustration shows a relapsing papular syphilide, localized upon the neck, the lesions assuming an annular or gyrate form.

In the third illustration is seen another patient whose appearance indicates a so-called scrofulous tendency, *i.e.*, the existence of weak unresisting tissues which seem to invite the invasion of the tubercle bacillus. Over the angle of the jaw a patch of lupus vulgaris, beginning as a group of nodules, had spread and ulcerated, and at the time the photograph was taken the ulcer was covered with a thick crust.

The fourth illustration resembles in outline the case of serpiginous lupus shown in Plate XLVII. But in the case of this patient, the slowly extending patch, instead of being nodular at the border (as is usual in lupus), shows a continuous line or ridge of waxy infiltration, quite characteristic of epithelioma. This is particularly well shown beneath the ear.



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SCROFULODERMA.
LUPUS VULGARIS.

SYPHILODERMA.
EPITHELIOMA.

PLATE LXXVI.

SYCOSIS

SYCOSIS

Sycosis, a disease peculiar to adult males, is the result of an inflammatory process in and around the hair follicles. Deep suppuration usually occurs and the pus reaches the surface of the skin between the hair and the follicular wall. The characteristic lesion thus formed consists of a pustule in the centre of which is a loosened hair. The disease usually attacks the bearded portion of the face, although other hairy parts are sometimes affected. It differs from eczema in causing a loosening of the hair, and in not extending from the bearded portion of the face upon adjacent regions which are not hairy. It is always non-parasitic, and the disease which is sometimes called sycosis parasitica is an entirely distinct disease, *viz.*, trichophytosis, or ringworm of the beard.

In the accompanying illustration the limitation of the disease to a hairy part is well shown upon the cheek and chin. An unusual amount of scaling and crusting is seen in this case (the patient having gone several days without shaving), but a few of the characteristic pustular lesions may be noted.

The cause of sycosis, especially when occurring upon the cheeks, is not always readily determined, but on the upper lip it is frequently the result of a chronic irritating nasal discharge.

Epilation of the loose hairs and such others in the inflamed area as will yield to gentle traction is one of the most effective methods of treatment. It speedily relieves the tenderness and swelling in most cases, although the operation may prove extremely painful when a high degree of inflammation is present.



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SYCOSIS.

PLATE LXXVII.

CHANCRE

CHANCRE

Syphilis is not always a venereal disease. In certain cases the primary lesion, an indurated infecting chancre, may be acquired in an accidental and innocent manner and occur upon various portions of the body, instead of upon the genital organs, where, for obvious reasons, it is most frequently found. The lips are especially liable to become the seat of an extra-genital chancre, either through kissing one affected with syphilitic oral lesions, or using a cup or pipe or holding in the mouth a pencil or other object which has been in the mouth of one affected with early syphilis.

In the first illustration the initial sclerosis is situated upon the skin above the vermillion border of the upper lip, and is covered by a thick crust. A swollen submaxillary gland, which is usually present in cases of labial chancre, had been treated by the application of some irritating ointment, causing a patch of dermatitis.

The second illustration presents a typical sclerosis occurring upon the lower lip. Such a lesion is unmistakable. Not infrequently, however, an irritated herpes or slight abrasion may become indurated and lead to more or less confusion in diagnosis.

In the third illustration is seen a palpebral lesion, which is one of the rare forms of extra-genital chancre.

A digital chancre, as seen upon the thumb in the fourth illustration, is liable to be acquired by any physician, dentist, or nurse in the examination of a patient suffering from recent syphilitic infection.

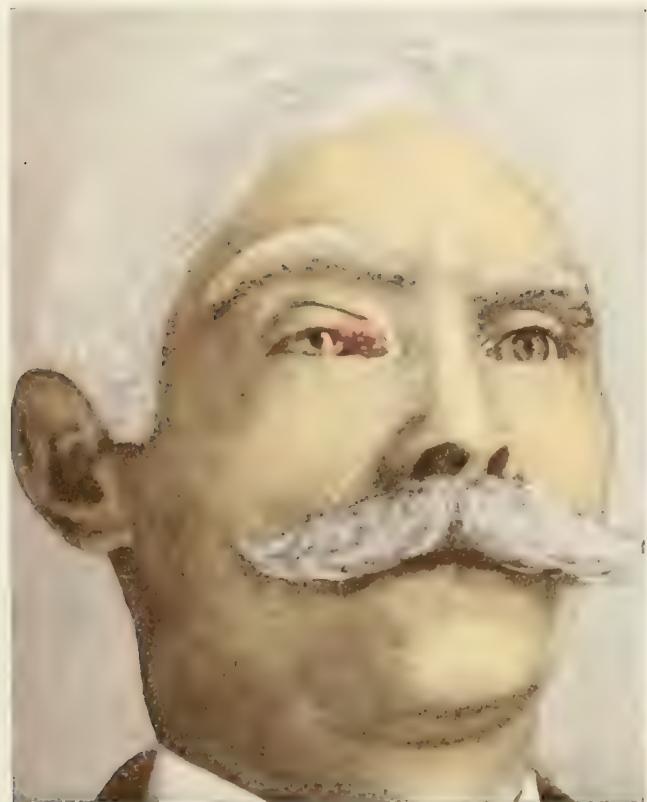
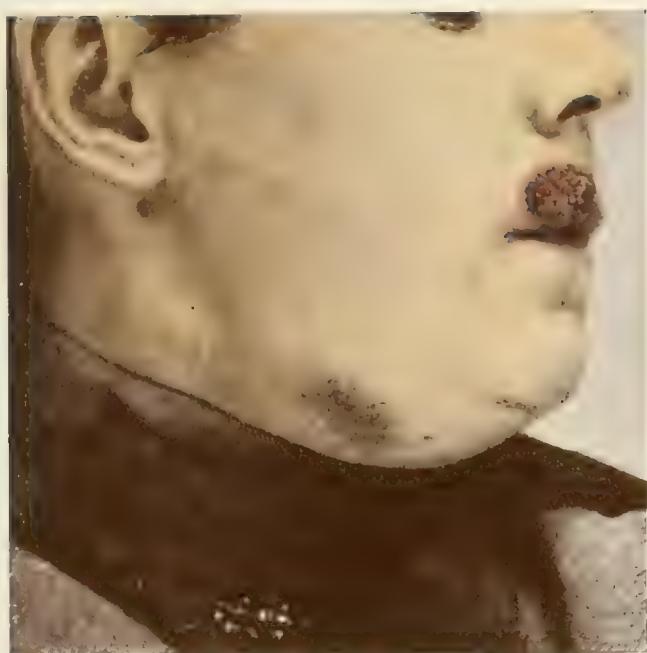


PLATE LXXVIII.

SYPHILODERMA ERYTHEMATOSUM

SYPHILODERMA ERYTHEMATOSUM

The erythematous syphilide when appearing as the first cutaneous symptom of the constitutional disease presents numerous small, rounded, pinkish macules scattered over the surface of the skin, and showing no tendency to occur in groups or circles. The relapsing erythematous eruption, which is comparatively rare and occurs later in the course of the disease, presents, on the other hand, fewer but larger erythematous patches, and sometimes an eruption in annular form.

The early erythematous syphilide is rarely observed to be as general and as distinct as in the case which forms the subject of the accompanying illustration. It is frequently seen only upon the abdomen and flexor aspect of the forearms, and often appears so faint as to resemble the mottling of the skin seen upon certain patients with a poor circulation when the body is stripped and exposed to a cool atmosphere. In most cases the macules do not exist alone but are associated with lesions of a more or less papular character. Indeed, the centre of a macule sometimes appears darker than its margin and is slightly elevated, and at this point a papule may develop.

In this patient the macular eruption developed suddenly about two months after the appearance of the chancre. It was of a bright red color at first, disappearing under pressure of the finger, and disappeared in a few weeks, gradually becoming duller in its hue and finally presenting the appearance of a faint, yellowish stain.



PLATE LXXIX.

SYPHILODERMA PAPULOSUM

SYPHILODERMA PAPULOSUM

The papular syphilide may occur in several forms, presenting a variety of clinical features. The miliary eruption consists of pinhead sized papules usually occurring in small clusters and is comparatively rare. The lenticular eruption, which is the most common form, is characterized by disseminated papules of split pea size. These may be few or numerous and are symmetrically distributed over head, trunk, and extremities. The large papular syphilide usually consists of fewer lesions which may be scaly, simulating psoriasis, circinate and resembling ringworm or moist and appearing like mucous patches upon the skin.

The unusually copious eruption upon the back shown in the illustration was of the ordinary lenticular variety. It had existed for about six weeks at the time the photograph was taken, and without treatment the lesions, especially upon the shoulders, were tending to flatten and disappear. Upon the lower portion of the back many of the papules were covered with scales, and some had softened and crusted so that the plate might have been designated as a papulopustular syphilide, although the papular element still predominated. It is rare indeed for an early syphilide to present throughout its course but one variety of primary lesion, and in many cases macules, papules and pustules will be found to coexist.



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SYPHILODERMA PAPULOSUM.

PLATE LXXX.

SYPHILODERMA PAPULO-SQUAMOSUM

SYPHILODERMA PAPULO-SQUAMOSUM

While the small papular syphilide usually disappears without any desquamation, the large flat papular syphilide is apt to present scaly discs which bear a strong resemblance to psoriasis and were formerly designated as syphilitic psoriasis. These scaly lesions when numerous are apt to occur in groups, forming irregular patches like the tuberculo-squamous syphilide seen in a later stage of the disease. The scales do not cover the whole of the papule as they do in psoriasis, but usually leave a reddish peripheral margin of infiltrated skin. Furthermore, while they may occur upon the extensor aspect of the extremities, and even upon the elbow as seen in the illustration, they are more likely to occur upon the thinner skin of the flexor surface, and frequently are seen upon the bend of the elbow and the popliteal space, where psoriasis never occurs. While the infiltration of the skin in the papulo-squamous syphilide is very marked, the scaling is usually comparatively slight. In psoriasis, on the other hand, the scaling is commonly found to be greatly in excess of the infiltration.

The eruption shown in the accompanying plate occurred several months after infection, as may be inferred from the grouping of the lesions which is never seen in the early lenticular syphilide. While the eruption presents a notable resemblance to psoriasis, its syphilitic nature might be inferred from the existence of lesions upon the nucha, where psoriasis is not commonly found, from the fact that the scaling is limited to the central portion of the infiltrated patches, and from their characteristic irregular border. In coalescing psoriatic lesions a circumscribed and scalloped border would be observed.

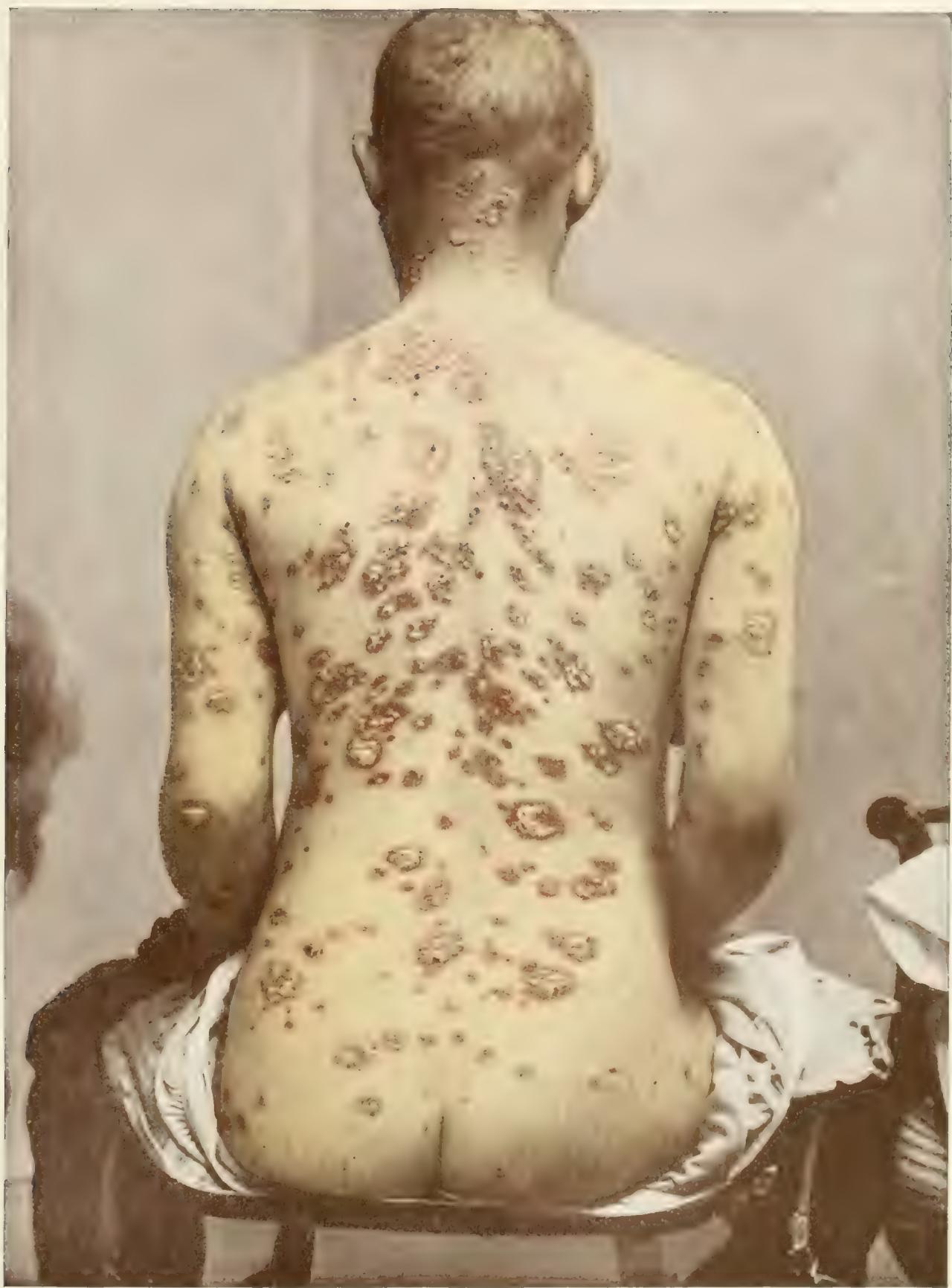


PLATE LXXXI.

SYPHILODERMA PUSTULOSUM

SYPHILODERMA PUSTULOSUM

Pustules of various size and form occur in the early disseminate eruptions of syphilis and constitute the true pustular syphilide. The softening tubercles and suppurating dermatitis occurring in the later eruptions are conveniently described in accordance with custom as the pustulo-crustaceous syphilide, although well-developed pustules rarely occur at this stage.

The pustular syphilide, like the papular form of the disease, may consist of small or large lesions. In the former case they are usually numerous and may be conical (acne-form) or rounded (variola-form). In the latter case they are fewer in number and manifest a tendency to increase in size and to become crusted (ecthyma-form). The pustular syphilide may occur as a relapsing eruption a few months after the earliest secondary outbreak, but generally it develops from a small or large papular syphilide through suppuration of the individual lesions. Frequently macules, papules, and a few pustules are found to co-exist and constitute a mixed eruption.

The accompanying plate shows an early pustular syphilide in which the lesions, instead of being small and rounded, manifest a tendency to remain flattened as they increase in size. The photograph was not taken until the eruption was beginning to disappear, and while a few lesions are still typical and ecthymatous in character, the older ones have mostly dried in the centre, leaving a crusted, serpiginous ring.



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SYPHILODERMA PUSTULOSUM.

PLATE LXXXII.

SYPHILODERMA TUBERCULOSUM

SYPHILODERMA TUBERCULOSUM

The nodular or tubercular syphilide is one of the later manifestations of the disease. While in rare instances it may occur during the first year after infection, it is commonly met with many years later.

The tubercles or nodular lesions in this form of syphilis are not necessarily larger than the papules of the early syphilide, as the name might imply, but they are always arranged in groups and are unsymmetrical, while the lesions of the early syphilides (macular, papular and pustular), whether few or many, are invariably disseminated, and one side of the body is almost a duplicate of the other.

The accompanying plate represents a tubercular syphilide of the serpiginous or creeping variety. It is evident at a glance that the most recent lesions have developed at the periphery of the patch and enclose an area from which earlier lesions have disappeared leaving more or less discoloration of the skin. Even the peripheral lesions appear to have become flattened and scaly and are evidently disappearing, as they frequently do, even without treatment. Such an eruption leaves no scars, but when nodules soften and ulcerate, small, smooth, whitish cicatrices remain as a permanent record.

This patient gave no history of syphilitic infection, but with such a characteristic eruption the diagnosis was unmistakable.



PLATE LXXXIII.

SYPHILODERMA ULCERATIVUM

SYPHILODERMA ULCERATIVUM.

In the early syphilodermata ulceration is uncommon, although in the large papular and pustular forms of the disease round superficial ulcers occasionally develop. In the late syphilodermata, ulceration of greater or less extent may be considered as the rule rather than the exception.

The tubercular or nodular eruption, appearing usually in groups, tends frequently to soften and to produce a number of superficial crusted ulcers. In some cases of serpiginous character a crescentic band of ulceration may be noted at the extending border of the patch.

The gummatous syphilide almost invariably softens and often causes deep and painful ulceration, which is followed by a disfiguring scar. The borders of syphilitic ulcers, whether superficial or deep, are usually quite abrupt and differ in this respect from the sloping edges of simple ulcers and the undermined border of scrofulous ulcers. Their specific origin can sometimes be inferred from this feature, but more frequently from their tendency to a circular or curving arrangement, and their localization upon the scalp and face and about the elbow and knee joints where traumatic or eczematous ulceration is not very likely to occur.

The accompanying plate shows an extensive patch of tubercular syphilis of the scalp of two years' duration. It had gradually spread at the periphery through successive development and ulceration of nodules. A large central area of cicatricial tissue had formed upon which the hair was destroyed, leaving a condition of permanent baldness. This ulceration healed rapidly under internal treatment.



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SYPHILODERMA ULCERATIVUM.

PLATE LXXXIV.

SYPHILODERMA

PUSTULOSUM

SQUAMOSUM

PAPULOSUM MILIARE

PAPULOSUM CIRCINATUM

SYPHILODERMA PUSTULOSUM
SYPHILODERMA SQUAMOSUM
SYPHILODERMA PAPULOSUM MILIARE
SYPHILODERMA PAPULOSUM CIRCINATUM

The four illustrations on this plate represent early phases of cutaneous syphilis, the eruptions being disseminate and symmetrical. These patients were all photographed within a few months after the appearance of the initial lesion, and a considerable portion of the body was affected in each case. Other symptoms, such as swelling of the glands, soreness of the throat, falling of the hair and arthritic pains, were present in a greater or less degree.

The first illustration shows a papulo-pustular eruption with an enlarged gland, near the angle of the jaw, resulting from ulceration of the fauces. As is usually the case, only a small proportion of the lesions have become pustular, and these vary in size and depth. One with a characteristic crater-like centre is seen upon the cheek.

The second illustration shows an eruption of larger flattened papules, most of which are tending to become squamous or slightly crusted. This tends to give the face an eczematous appearance, and such an eruption has been considered by some to be a combination of syphilis and seborrhœic eczema.

The third illustration shows the miliary form of the papular syphilide. The small conical papules tend to aggregate in clusters, and present an appearance quite different from the pea-sized lesions of the lenticular form of the papular syphilide, which are far more common.

The fourth illustration portrays a still rarer form of early syphilis. The papules are of the large flat type, and many of them have become superficially ulcerated, the surface being moist or diphtheritic and suggestive of mucous patches upon the skin. These lesions tend to heal in the centre and thereby assume an annular form.



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PUSTULOSUM.
PAPULOSUM MILIARE.

SYPHILODERMA.

SQUAMOSUM.
PAPULOSUM CIRCINATUM.

PLATE LXXXV.

SYPHILODERMA

PAPULOSUM

TUBERCULO-SQUAMOSUM

SERPIGINOSUM

VERRUCOSUM

SYPHILODERMA PAPULOSUM
SYPHILODERMA SQUAMOSUM
SYPHILODERMA SERPIGINOSUM
SYPHILODERMA VERRUCOSUM

Of the four illustrations on this plate the first shows an early syphilitic eruption, while the remaining three portray late manifestations of the disease.

The plantar surface, while not so frequently affected by syphilis as the palms, and more frequently overlooked when it is affected, may be the seat of a papular eruption quite similar to that so often seen upon the palms. In either location the eruption is so characteristic and unlike that arising from any other cause that the diagnosis may be considered as written upon the skin.

The late tuberculo-squamous eruption occurring upon either the palms or the soles (as seen in the second illustration) is not always so characteristic, and in many cases its resemblance to eczema is so marked that the most expert diagnostician is puzzled to decide upon the nature of the eruption. In the case photographed the elevated and somewhat scalloped border of the patches would speak strongly in favor of syphilis.

The third illustration shows infiltrated patches with a healing centre and a raised margin. The latter tends to advance in a serpiginous or creeping manner, often healing on one side while spreading on the other, and thereby producing gyrate lines or patches of a horseshoe or kidney shape.

The fourth illustration shows a rare form of late syphilis usually affecting the hands or feet, and characterized by a warty condition of the skin, with or without ulceration. This eruption has been termed syphiloderma vegetans. A somewhat similar condition of the cutaneous surface may be found in ichthyosis and in certain cases of chronic eczema.



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PAPULOSUM.
SERPIGINOSUM.

SYPHILODERMA.

TUBERCULO-SQUAMOSUM.
VERRUCOSUM.

PLATE LXXXVI.

SYPHILODERMA

PAPULO-SQUAMOSUM	SERPIGINOSUM
DACTYLITIS	ULCERATIVUM

SYPHILODERMA MANUS

Syphilis affects the hand both in the early and the late stages of the disease, and here as elsewhere its characteristic features are observed. A variety of clinical appearances may be presented, four of which are shown in the accompanying plate.

In the upper left illustration is seen the scaling papular syphilide. This usually coexists with one of the early disseminate eruptions. Owing to the thickness of the palmar epidermis it may develop slowly and not appear in full bloom until the papular or pustular eruption, of which it is a part, has almost disappeared from other portions of the body. Unlike the late squamous syphilide, it always affects both palms. The large number and small size of the lesions prevent its being mistaken for eczema.

The upper right illustration presents a scaling patch of syphilis occurring late in the course of the disease. The dull red hue of the patch together with its elevated and scalloped border constitute a clinical picture which speaks unerringly of its specific origin.

The lower left hand shows evidence of inherited syphilis in the osseous swelling affecting two of the first row of phalanges. Suppuration and ulceration often occur in such cases which are thereby brought within the province of dermatology.

The lower right hand presents a characteristic kidney-shaped and deep ulcer resulting from the softening of a gummatous deposit.

C. Syphilis. Part. 1. XV. G. II. F. A.

A. PAPULO-SQUAMOSUM.
B. DACTYLIITIS.

SYPHILODERMA.

C. SERPIGINOSUM.



PLATE LXXXVII.

SYPHILODERMA PAPULO-SQUAMOSUM
PSORIASIS DIFFUSA
TUBERCULOSIS CUTIS

SYPHILODERMA PAPULO-SQUAMOSUM
PSORIASIS DIFFUSA
TUBERCULOSIS CUTIS

This plate shows three totally different diseases affecting the same locality.

In the upper illustration is seen a papulo-squamous syphilide, which bears a resemblance to psoriasis. Indeed, when scaling syphilitic papules occur about the elbows and coalesce, as in this case, a hasty and erroneous diagnosis might be made. But the slight scale formation, as compared with the marked thickening of the lesions, is a point in differential diagnosis which should tend to dispel any confusion.

In the middle illustration is again presented a coalescence of scaling papules. But these scales are thick and silvery in appearance—not a slight cracking and peeling of the epidermis, as seen above. Moreover, they do not overlay an infiltrated or lumpy condition of the skin, as in the papular syphilide. The scaling is the main feature of the eruption. The white discs have coalesced for the most part, and present the unmistakable features of psoriasis diffusa. If the flexor aspect of the arms of these two patients were visible, we would doubtless find the psoriatic eruption comparatively sparse, if not entirely absent, while the syphilide would probably appear as abundant as upon the extensor surface, and very likely appear in the bend of the elbow, where psoriasis rarely if ever occurs.

The lower illustration shows the infiltrated patches with a roughened surface or an ulceration with an irregular and undermined border, which is characteristic of tuberculosis of the skin. The eruption might suggest syphilis, but its very slow growth, together with the absence of any annular or serpiginous character, would at once suggest a non-syphilitic origin.



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SYPHILODERMA PAPULO-SQUAMOSUM
PSORIASIS DIFFUSA
TUBERCULOSIS CUTIS

PLATE LXXXVIII.

SYPHILODERMA HEREDITARIUM

SYPHILODERMA HEREDITARIUM

Syphilis occurring in childhood is usually, though by no means invariably, the result of inherited disease. Infants at the breast may acquire syphilis as well as adults and the resulting eruption is not unlike that seen in later years.

The inherited disease may develop *in utero*, in which case a large proportion of infants are born dead. It may manifest itself in an eruption at birth or this may develop any time during the first year. As a rule, however, the symptoms of inherited syphilis appear during the first three months. Emaciation is one of the most common symptoms and the syphilitic infant with wrinkled face, sallow skin, and fretful cry often presents a tiny caricature of old age. A characteristic coryza or "snuffles" usually develops and interferes with nursing and ordinary breathing.

The inherited eruption in infancy may be macular or papular and, in the latter case, show a decided tendency to become moist and to ulcerate, especially about the mucous orifices, in the axillæ, and on the buttocks. The palms and soles are often the seat of a bullous eruption. In childhood nodular and gummatous lesions may develop and cause destructive ulceration coexistent with osseous and visceral lesions.

The face of the young girl represented in the plate presents unmistakable evidences of the baleful legacy which has destroyed one eye, the nose, and a portion of the lip.

In the lower illustration is seen the characteristic notching of the upper central incisor teeth, described by Hutchinson. This occurs with the second dentition.



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SYPHILODERMA HEREDITARIUM.

PLATE LXXXIX.

TRICHOPHYTOSIS

TRICHOPHYTOSIS.

Trichophytosis, or ringworm, is a parasitic disease affecting both hairy and non-hairy parts and due to the growth of certain fungi in the hair and epidermis. The name of the disease implies that it results from the growth of the trichophyton, which seems to be the case in some European countries, but in France and England other fungi (and particularly the microsporon Audouini) are found to cause the majority of cases.

Ringworm of non-hairy parts is a trifling affection and readily cured, but when the spores of the vegetable growth find their way into the hair follicles, as they frequently do upon the heads of children, a serious and obstinate disease is the result. Upon the bearded portion of the face the disease is not always easy to cure when it has existed for some time, and when the nails become affected, as not infrequently happens, the disease is an extremely chronic and rebellious one.

The accompanying plate shows patches of ringworm upon different portions of the body. Upon a boy's head is seen the characteristic tonsure produced by the disease. The circular patch might suggest alopecia areata at first glance, but in place of the smooth, velvety skin of the latter, we find a furfuraceous desquamation and many short broken hairs. Upon the wrist is an extensive scaly patch presenting a raised and slightly inflamed margin. Usually, the circular patch begins to heal in the center while the ring is quite small, and then the typical scaly circle is formed such as is seen upon the cheek.



PLATE XC.

TUBERCULOSIS VERRUCOSA

TUBERCULOSIS VERRUCOSA

Like lupus vulgaris, the somewhat rare affection known as tuberculosis verrucosa is the result of the infection of the skin by the tubercle bacillus. It has been termed by some writers lupus verrucosus, although the characteristic tubercles of lupus are never present. In one patient, I have noted this eruption upon the dorsum of the foot, while a patch of typical lupus vulgaris was present upon the arm. The hands are most frequently affected, and the disease usually begins as a small warty growth over one or more of the knuckles. Its course is a slow one and there is no tendency to spontaneous recovery, although the central portion of the patch may be converted into a cicatricial area. Fissures and raw spots may be noted but there is never any extensive ulceration.

The accompanying plate presents three illustrations of the disease. The upper hand, that of a young man, shows the simplest and most frequent form. The patch has become flattened and manifests a slight serpiginous tendency. The lower hand, that of a man aged forty-five, shows an extensive and typical form of the disease. The eruption in this case improved under treatment at the outdoor department of the Skin and Cancer Hospital, but after the patient had allowed eight years to elapse between visits it was found to have increased considerably in extent. Curetting beneath a spray of ethyl chloride is a plan of treatment which in such cases promises the best results. The boy, nine years old, whose leg is portrayed, had no eruption save the patch in the popliteal space which was of eighteen months' duration.



PLATE XCI.

URTICARIA

URTICARIA

Urticaria is the only disease which can lay sole claim to one of the primary lesions of the skin—the wheal. This is a rounded, linear or irregular, but always circumscribed, œdema of the skin. It develops usually in a few minutes and rarely lasts longer than a few hours. External causes, such as a mosquito bite or contact with a nettle, may produce but one or a few wheals. In urticaria of internal origin a large portion of the body may be affected.

The upper illustration of the accompanying plate shows a peculiar neurotic condition of the skin which may present a perfectly normal appearance until some external irritation evokes the characteristic wheals. This condition has been described as *urticaria factitia* or *dermographism*. In the patient, whose back is shown, it had existed since childhood. About five minutes before the photograph was taken the crosses and lettering were gently scratched upon the skin by means of a dull pointed instrument. Congestion of the part appeared immediately and in less than a minute the white lines developed and gradually became raised abruptly above the surface. In nearly as short a time they had flattened and faded, leaving merely a trace of redness upon the skin.

The lower left illustration shows the typical wheals of urticaria occurring upon the thigh of a patient who suffered from acute indigestion.

The lower right illustration shows a number of wheals produced by scratching. The flat surface is reddened or slightly excoriated, while a white band remains at the margin.



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URTICARIA.

PLATE XCII.

VARIOLA VESICULOSA
VARIOLA PUSTULOSA

VARIOLA

The two cases of Variola which are reproduced in the accompanying illustration were photographed by the author at the Riverside Hospital, on North Brothers' Island, an institution under the control of the New York Board of Health.

The photograph of the vesicular stage was taken on the seventh day of the disease, just before the isolated lesions were beginning to assume the umbilicated character which is noted usually on the eighth or ninth day. At this period the contents of the vesicles become purulent and an inflammatory halo develops around each separate lesion. This was an exceptionally severe case, as may be seen by the intense congestion of the face and the confluence of the vesicles.

The photograph of the pustular stage was taken on the eleventh day of the disease when most of the unbilicated pustules had become tense and hemispherical. A few umbilications may still be seen upon the forehead. This notable change in the appearance of the lesions results from a loosening of the trabecular bands, which produce the umbilication, a characteristic feature which is most marked at a time when the lesions are passing from the vesicular into the pustular stage.

In determining the previous duration of the disease from the stage of development of the lesions, it should be borne in mind that the pocks upon the face, where the eruption begins in Variola, are apt to be two or three days more advanced than upon the extremities, and that in some cases of Varioloid the lesions may appear first upon the trunk, occur in successive crops, and perhaps desiccate within a week.

VARIOLA VESICULOSA.



PLATE XCII.

VITILIGO

VITILIGO

The backs of the hands are the most frequent site of vitiligo, and in many cases the affection is confined to this locality. In other cases the white spots appear upon the face and neck as well, and not infrequently are found upon the trunk and extremities. In the negro race the affection sometimes increases until the greater portion of the skin becomes white.

In this patient, a man of nearly seventy years, the patches had existed for a long time and shown little tendency to increase in size or to appear elsewhere. As is usual, the skin around the white patches had assumed a slightly darker hue and, as the patient was naturally of a dark complexion and the photograph was taken in the summer time, when the hands were tanned through exposure to the sun, the contrast was exceptionally well marked.

The patient suffered no discomfort whatever from the spots and no treatment was employed. In fact, there is little that can be done in such a case beyond lessening the intense contrast of color by keeping the hands from exposure to the sun and by bleaching the darker skin by the frequent application peroxide of hydrogen. Aside from its disfigurement, the only disadvantage arising from vitiligo upon the hands is the marked tendency of the unpigmented skin to redden and blister when exposed to the rays of a summer sun.



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VITILIGO.

PLATE XCIV.

XANTHOMA TUBEROSUM

XANTHOMA

Xanthoma is a neoplastic disease beginning in the deeper layer of the corium and characterized by circumscribed yellowish patches or nodules of varying size. The most common form of the disease, called xanthoma planum, usually affects the eyelids and appears in the form of one or more rounded or elongated dull yellow patches near the inner canthus. They may be slightly elevated and are often symmetrical. Beyond the slight disfigurement they occasion no discomfort. This smooth variety of the disease sometimes occurs in streaks following the lines of flexure upon the palms (xanthoma striatum).

The nodular form of xanthoma occurs chiefly upon the lower portion of the back and upon the extensor aspect of the extremities. The lesions are usually numerous and vary in size from small rounded papules to lobulated masses as large as a hen's egg. They are of a dull yellow tint and firm in consistence.

The cause of the disease is obscure in many cases and patients often appear to be in excellent physical condition. The nodular eruption, however, frequently occurs in diabetic subjects and some writers regard this glycosuric xanthoma as a distinct disease.

The upper illustration shows an exceptionally large tumor upon the elbow consisting of an aggregation of smaller tumors with a few outlying tubercles. The lower illustration presents a characteristic grouping of small tubercles over the hips and buttocks. This patient was suffering from diabetes mellitus and the eruption disappeared as soon as the glycosuria was successfully treated.



PLATE XCV.

ZOSTER PECTORALIS

ZOSTER PECTORALIS

The gradual and even course which Zoster usually runs enables one to judge quite accurately the age of the eruption by the appearance of the lesions. As some of the patches, however, may develop a few days later than the primary patch, these will naturally be found to be in a less advanced stage of development. While some of the vesicles in a given case may be tense and filled with clear serum, the vesicles on patches a day or two older may appear flattened and of a milky hue.

In the subject of the illustration the eruption had existed for six days at the time when the photograph was taken, but the boy had complained of pain for a day or two before the first red patch was noted. Upon the side the vesicles are seen to be at their height of development, while nearer the spine, where the eruption evidently first appeared, they show a tendency to confluence, and of a purulent character. At three points it is evident that they have been irritated or broken, doubtless by the friction of the clothing, and small, dark, hemorrhagic crusts have formed.

In the treatment of Zoster many of the applications in common use have no curative effect and frequently add to the discomfort of the patient. If a simple dusting powder is used, and the inflamed skin carefully protected by a soft linen cloth, the disease will run its course and the patient be more comfortable than when the affected part is painted with collodion or smeared with an ointment. Galvanism applied by means of a metallic roller attached to the negative cord furnishes the best means of relieving the intense neuralgic pain which is often present in elderly patients.



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ZOSTER PECTORALIS.

PLATE XCVI.

ZOSTER

FRONTALIS

CERVICO-CLAVICULARIS

FEMORALIS

BRACHIALIS

ZOSTER

This plate represents Zoster as it appears upon different parts of the body. Each illustration shows the characteristic grouping of the vesicles, and in three of them the unilateral character of the disease is evident.

Zoster frontalis is always attended with the severest neuralgic pain and of all the regional varieties of the disease, this is most apt to leave permanent scars. It always causes considerable œdema of the lids, and permanent injury of the eye not infrequently results.

Zoster of the neck usually extends from the cervical vertebrae to the sub-clavicular region. It may involve the occiput and auricle, or run downward over the shoulder, as in the case illustrated.

Zoster femoralis may extend from the sacrum to the popliteal space, and even run down to the foot in exceptional cases. In the case illustrated it was limited to a single patch.

Zoster brachialis usually begins in the scapular region, extends over the shoulder and down the flexor aspect of the arm. In rare instances it may even be noted upon the palm.

While Zoster of the chest or abdomen is usually recognized at once on account of its unilateral distribution, Zoster of the arm or leg is very apt to be mistaken for eczema or some other affection, unless the peculiar grouping of the vesicles and their tendency to dry and flatten is carefully noted.



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FRONTALIS
FEMORALIS

ZOSTER

CERVICO-CLAVICULARIS
BRACHIALIS

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